The Rhetoric of Partnerships Involving People Who Use Illicit Drugs and the Reality of 'Partners' Experience

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Declaration

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The research associated with this thesis abides by the international and Australian codes on human and animal experimentation, the guidelines by the Australian Government's Office of the Gene Technology Regulator and the rulings of the Safety, Ethics and Institutional Biosafety Committees of the University.

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Peter V. Lucas **Date**

Abstract

The rhetoric of partnerships involving people who use illicit drugs and the reality of 'partners' experience.

This research examines the concept of partnerships as it applies to illicit drug policy development and service delivery planning processes in Australia. It poses the question: 'How does the rhetoric of partnerships involving people who use illicit drugs match the experience of partners?' The research concludes that, with a few exceptions, the concept of partnerships involving people who use illicit drugs is little more than a rhetorical tool used by neoliberal forms of government.

The research adopts a theoretical framework of 'governmentality' initially developed by Michel Foucault. A governmentality approach identifies the rationalities behind strategies adopted to enhance the productivity of populations, as well as the various 'technologies' employed to achieve desired outcomes. Suggestions for augmenting a governmentality approach for better understanding partnerships involving people who use illicit drugs are proposed as part of this research.

The methodology comprises two components. The first involves analysis of a range of policy documents relating to illicit drug use to trace the evolution of the concept of partnerships with people who use illicit drugs. The second component involves in-depth interviews with members of the 'drug policy community', including policy makers, service providers and members of peer-based user advocacy organisations.

The perception of those working in these 'partnerships' was that this neoliberal concept fell well short of aspirations and expectations. The key factors identified by 'partners' that limit the success of this approach are discussed in detail. These include: the impact of a morally conservative dominant discourse of prohibition; the political nature of what counts as 'evidence' in policy development and service delivery planning processes; and a lack of institutional support for genuine partnerships with people who use illicit drugs from governments, policy makers and service providers.

The research also finds that the theoretical framework of governmentality is a useful analytical tool for understanding the concept of partnerships involving people who use illicit drugs. I argue that in order to better understand these partnerships, and the reasons why this enterprise has had only limited success, it is important to incorporate other theoretical perspectives alongside that of governmentality. These include: the 'political economy of drug user scapegoating' (Friedman, S. 1998); the medicalisation of substance use (Freund and McGuire 1991; Szasz 1974; White 2002); and the concept of 'authoritarian liberalism' (Dean 2002; Hindess 2001).

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List of Acronyms

ACT - Australian Capital Territory

AIVL - Australian Injecting and Illicit Drug Users League

ANCARD - Australian National Council on AIDS and Related Diseases

ANCD - Australian National Council on Drugs

ATDC - Alcohol, Tobacco and Other Drugs Council of Tasmania

DCSH - Department of Community Services and Health

DFA - Drug Free Australia

DHAC - Department of Health and Aged Care

DHHS - Department of Health and Human Services (Tasmania)

DHHLGCS - Department of Health Housing Local Government and Community Services

DOHA - Department of Health and Ageing

HCV - Hepatitis C virus

HIV/AIDS - Human immunodeficiency virus and acquired immune deficiency syndrome

IAWGD - Inter Agency Working Group on Drugs

IDRS - Illicit Drug Reporting System

IGCD - Intergovernmental Committee on Drugs

ICSDP - International Centre for Science in Drug Policy

MCDS - Ministerial Council on Drug Strategy

NAPID - National Action Plan on Illicit Drugs 2001 to 2002-03

NCADA - National Campaign on Drug Abuse

NCHSR - National Centre in HIV Social Research

NDSF - National Drug Strategic Framework 1998-99 to 2002-03: Building Partnerships

NDSP - National Drug Strategic Plan 1993-1997

NDS - National Drug Strategy

NSP - Needle and syringe programs

NSW - New South Wales

NUAA - NSW Users & AIDS Association

TDS - Tasmanian Drug Strategy 2005-2009

TDPF - Transform Drug Policy Foundation

TDSP - Tasmanian Drug Strategic Plan 2001-2004

TUHSL - The Tasmanian Users Health Support League

UK - United Kingdom

USA - United States of America

VIVAIDS – Victorian Drug Users Organisation (now Harm Reduction Victoria)

WHO - World Health Organisation

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Chapter 1 - Introduction - Partnerships, Governmentality and Drugs

1.1 Research Overview

This research examines the concept of partnerships as it applies to illicit drug policy development and service delivery planning processes in Australia and poses the question: 'How does the rhetoric of partnerships involving people who use illicit drugs match the experience of partners?' The research concludes that, with a few exceptions, the concept of partnerships involving people who use illicit drugs is little more than a rhetorical tool used by neoliberal forms of government that resists a rational approach. Instead it is more a moral enterprise based on political calculations rather than a sound evidence base.

The perception of those working in these 'partnerships' was that this neoliberal concept fell well short of aspirations and expectations. The key factors identified by 'partners' that limit the success of this approach are discussed in detail. These include: the impact of a morally conservative dominant discourse of prohibition; the political nature of what counts as 'evidence'; and a lack of institutional support for genuine partnerships with people who use illicit drugs from governments, policy makers and service providers.

The research also finds that the theoretical framework of governmentality is a useful analytical tool for understanding the concept of partnerships involving people who use illicit drugs. In my discussion I argue that in order to better understand these partnerships, and the reasons why this enterprise has had only limited success, it is important to incorporate other theoretical perspectives alongside that of governmentality. These include: the 'political economy of drug user scapegoating' (Friedman, S. 1998); the medicalisation of substance use (Freund and McGuire 1991; Szasz 1974; White 2002); and the concept of 'authoritarian liberalism' (Dean 2002; Hindess 2001).

1.2 Governmentality and Drug Policy: An Ideal Model versus Actual Practice

In the following section of this chapter I develop a model of an 'ideal governmentality' approach to drug policy and service delivery development processes, and contrast this with the reality of how these processes actually operate in contemporary Australia. I outline the explanatory framework adopted to examine the limited success of partnerships involving people who use illicit drugs in policy development and service delivery processes. This foundation makes clear the inherent tension between an 'ideal governmentality' approach and current actual practices in these processes, a tension that I discuss in detail in later chapters. The objective is to provide an overview of the argument I develop in subsequent chapters which applies a 'governmentality' theoretical framework to make sense of the practices that shape Australia's current response to the issue of illicit substance use. This follows Weber's suggested construction of an 'ideal type' whereby through making

> comparison with this it is possible to understand the ways in which actual action is influenced by irrational factors of all sorts … in that they account for the deviation from the line of conduct which would be expected on the hypothesis that the action were purely rational (Weber 1964:92).

The conception of an 'ideal governmentality' model for responding to drug related harms is an extension of Foucault's theory, an approach of which he may not have approved. However, as I discuss in Chapter Two, there is no agreed orthodoxy within the 'governmentality school' and this provides researchers with the opportunity to use this theoretical framework in a creative manner. As such, I consider this approach a useful analytical tool for understanding contemporary approaches to drug policy and the involvement of drug users in this process.

An 'ideal governmentality' approach would recognise the primacy of the self-governing autonomous citizen, consistent with liberal ideals, and enable them the freedom to make choices about their consumption of commodities (Hathaway 2002). Currently, distinctions are made between licit and illicit substances that contradict

liberal principles of the individual as a freely choosing entrepreneurial actor in a consumer society (O'Malley and Valverde 2004). This prohibitionist approach views individuals who use proscribed substances as incapable of developing the necessary 'technologies of the self'. The concept of 'technologies of the self' is a defining feature of a neoliberal governmentality approach to rule (Dean 1999; Foucault 1984b; Lupton 1995; Rose 1999), that I discuss in more detail in following chapters where I argue this demonstrates the inherent tensions evident in a neoliberal governmentality approach to substance use.

An 'ideal governmentality' approach to drug use would adopt a rational, evidence-based approach to drug use consistent with neoliberal principles (Barry et al. 1996; Rose 1993). As I argue in later chapters, however, there is a denial that the current 'war on drugs' prohibitionist approach has actually led to greater harms (ICDSP 2010) than if currently proscribed drugs were regulated and subjected to market forces as are most other commodities (TDPF 2010; Wodak and Moore 2002). Instead, what is seen in practice is a 'policy-based evidence' approach rather than the 'evidence-based policy' approach (Hughes 2007) that would be expected under an 'ideal governmentality' model. This inherent tension is the result of a morally charged, abstinence-based dominant discourse based on political calculations that treats all illicit drug use as pathological.

An 'ideal governmentality' approach would recognise the unique expertise that people who use illicit drugs possess, consistent with Foucault's notion of the 'specific intellectual' (Foucault 1994c:129), and would seek to utilise this expertise in efforts to reduce the harmful effects of substance use. Neoliberal forms of government rely on 'expert knowledge' (Gordon 1994; Petersen and Lupton 1996; Turner 1997) to enable 'governing at a distance' consistent with principles of freedom and autonomy (Rose 1993, 1999). Recognition of this expertise would result in the meaningful engagement of people who use illicit drugs in partnerships that sought to develop effective policies and treatment programs to reduce drug related harms. These partnerships, as I discuss below, are consistent with neoliberal visions of 'active citizenship' aimed at maximising the potential of the resource of population for the benefit of the state

(Dean 1995, 1999; Lupton 1995). Instead what is seen in practice is an abstinence-based zero tolerance discourse that is politically motivated and serves to undermine the potential of a partnership approach that meaningfully engages users in policy development and service delivery planning processes. Again the inherent tension between an 'ideal governmentality' approach and actual practice is evident in the failure to provide adequate institutional support that would enable such partnerships to prosper. In the following section I provide an overview of partnerships in health policy and service delivery planning processes as an entree for how I utilise this concept in this dissertation.

1.3 Background – Health Promoting Partnerships

The involvement of consumers of health services in policy development and service delivery planning processes has become a defining feature of contemporary neoliberal societies under the banner the 'New Public Health' (Petersen and Lupton 1996). In areas of chronic disease such as diabetes, asthma and mental health this practice has been widely adopted with the aim of achieving better health outcomes, as well as reducing the burden of illness on the community. Involving consumers in these processes is typically referred to as a 'partnership' approach whereby policy makers, service providers and consumers work together in formulating policy responses and planning services.

Such an approach

> seeks to include consumers of services in decision-making about service planning and delivery, and policy development. On an ideological level, it is thought to add legitimacy to service providers' decisions about health service delivery, provide service consumers with a venue through which to demand accountability from service providers, and increase the sharing and valuing of consumer experiences and knowledge (Bryant et al. 2008b).

The effectiveness of this practice in health promotion and disease prevention has been widely evaluated across a variety of health and wellbeing sectors and has been found

to be an effective strategy for improving health outcomes. Gillies' (1998) research found that

> a range of partnership initiatives to promote health across sectors, across professional and lay boundaries and between public, private and non-government agencies, do work. They work in tackling the broader determinants of health and wellbeing in populations in a sustainable manner, as well as in promoting individual health-related behaviour (Gillies 1998:99).

Other research that reviewed a sample of case studies of such partnerships found that evidence of the effectiveness of this practice suggests that 'implementation of collaborative partnerships is associated with improvements in population-level outcomes' (Roussos and Fawcett 2000:375).

The comments above indicate that partnerships with consumers in improving health outcomes *do* improve health outcomes, although this appears to be conditional on a range of factors. Many studies of such partnerships focus on

> process issues, such as how well the partners work together in addressing joint aims and the long-term sustainability of the partnership [while others focus on] outcome issues, including changes in service delivery, and subsequent effects on the health or well-being of service users (Dowling et al. 2004:309).

This research analyses both these aspects of partnerships. The primary focus is on process issues and, specifically, how the rhetoric of partnerships contained in a range of policy documents and strategic plans corresponds with the experience of those actors involved in partnerships. Outcome issues are also covered, although not in such depth, and serve primarily as exemplars of the successful engagement of people who use illicit drugs in policy development and service delivery planning processes. In the following section I provide a background of the practice of partnerships involving people who use illicit drugs in Australia.

1.3.1 Partnerships Involving Drug Users in Australia

Partnerships involving people who use illicit drugs were considered a key factor in maintaining low rates of HIV/AIDS infection among injecting drugs users as one component of the strategic response to containing the virus in the early 1980's in Australia. The centrality of involving 'affected communities' in formulating policies and developing services gained a reputation for Australia as a world leader in developing effective responses to the HIV/AIDS pandemic (ANCARD 1999; Feachem 1995; Hinton 2010; Single and Rohl 1997). The concept of partnerships and the involvement of 'affected communities' has also been a feature of numerous government policy documents and strategic plans aimed at reducing a range of drug related harms over the last few decades, as I discuss in Chapter Five.

In most States in Australia, as well as at a national level, there are government funded peer-based illicit drug user organisations that work, to some extent at least, in partnerships with policy makers, service providers and people who use illicit drugs. One notable exception is Tasmania, where there have been several attempts by illicit drug users to establish a peer-based service, however, these have all foundered due to a range of factors. A key objective of this research is to illuminate why this is the case. Government funding to these organisations is aimed at reducing a range of drug related harms among a group of people that are often reluctant to access mainstream services due to the illicit nature of their consumption choices. These peer-based organisations can be viewed as a means of governing this population in an indirect manner, at a distance - to use a 'governmentality' concept that I discuss in more detail throughout this thesis. Drug user organisations are also characteristic of neoliberal approaches to the provision of health services that has seen a retreat from service provision by government agencies and a concomitant increase in non-government and private sector service provision. These services are generally financed through an array of government funding and grants programs through a 'purchaser-provider' model (Fitzgerald 2004:58) that is another defining feature of contemporary neoliberal social policy (Bunton 2001). The practice of partnerships involving people who use illicit drugs is discussed in more detail in Chapter Three. Having now

provided an overview of the key aims of this research, in the following section I provide an outline of the structure of this thesis.

1.4 Thesis Structure

Chapters Two and Three outline the theoretical framework that I employ to analyse the concept of partnerships involving people who use illicit drugs. In Chapter Two I provide an overview of Foucault's concept of governmentality, and discuss how others have applied it to a variety of topics. I argue that the concept of governmentality offers a useful theoretical framework for understanding partnerships within neoliberal regimes. I provide an overview of the emergence of liberal and neoliberal forms of government as described in much of the governmentality literature and also discuss the concepts of 'authoritarian' or 'despotic' liberalism evident in liberal approaches to governance (Hindess 2001; Valverde 1996). I also discuss some of the contradictions evident in neoliberal responses to substance use in contemporary consumer societies. Further, I discuss how the concept of harm minimisation can be viewed as a governmentality project aimed at maximising the potential of the 'resource' of population and reducing drug related harms in the community. Finally, I argue that in order to better understand contemporary responses to illicit substance use it is critical to incorporate the concept of 'the political economy of drug user scapegoating' (Friedman, S. 1998) alongside a governmentality approach.

Chapter Three continues to develop the theoretical framework relating to the concept of partnerships involving people who use illicit drugs. In this chapter I discuss theoretical concepts of medicalisation, the 'New Public Health' and evidence-based policy, and how they relate to contemporary responses to substance use. I discuss how governments have adopted the rhetoric of 'partnerships', involving a range of stakeholders including people who use illicit drugs, and argue that they form part of a neoliberal enterprise aimed at conveying a sense of inclusion in policy development and service delivery planning processes. In this chapter I argue that pharmacotherapy programs, such as methadone maintenance, are an ideal technology for keeping deviant populations under surveillance - a phenomenon I describe as a pharmaceutical

panopticon. In this chapter I again offer suggestions for augmenting a governmentality framework to enable a more sophisticated understanding of the concept of partnerships involving people who use illicit drugs.

Chapter Four discusses the methodology employed in the research. In this chapter I posit that Critical Discourse Analysis is a useful method for understanding how illicit drug policy, and the concept of partnerships involving people who use illicit drugs, has evolved in Australia. In Chapter Four I also suggest that in order to better understand how people working within partnerships experience this discursive construct, that an ethnographic approach involving in-depth interviews with key stakeholders is a method that augments Critical Discourse Analysis. Finally, in this chapter I propose that adopting these two methods in my research enables the rhetoric contained in the policy documents and strategic plans to be compared with the experiential perspective of those working in the field. This approach addresses some of the criticism that has been made of governmentality analyses of social policy in the past (McKee 2009).

In Chapter Five I analyse a range of policy documents, strategic plans and evaluation reports from the drug policy field, as well as from the HIV/AIDS and hepatitis C sectors, to trace the evolution of the concept of partnerships with people who use illicit drugs. In this chapter I argue that the structure of these documents and the language used in them reflects an increasing refinement of a governmentality approach to managing illicit substance use. Also in this chapter I examine the 'expert bodies' and processes involved in the development of these documents to support my argument. The gradual erosion of a harm minimisation approach and the shift towards a "Tough on Drugs" discourse under the Howard Government is also discussed in this chapter, as factors that impact negatively on partnerships involving people who use illicit drugs.

Chapters Six and Seven analyse the findings from interviews with 15 key stakeholders working within partnerships. In Chapter Six I discuss some of the positive and negative perceptions of partnerships that were recurring themes in the

interviews, and also identify what I describe as ‘enablers’ and ‘barriers’ to successful partnerships. In this chapter I also discuss a range of issues that were raised during the interviews that specifically impact on the viability of a sustainable peer-based user organisation in Tasmania. This is important for understanding why there have been a number of failed attempts to establish such a group in Tasmania, but also for the sustainability of existing organisations in other States.

In Chapter Seven I review a range of other issues that participants in the interviews felt impacted on the successful workings of partnerships involving people who use illicit drugs. These include issues such as expert knowledge, power and social control that are also key Foucauldian concepts. I also discuss the neoliberal concept of evidence-based policy and highlight the contested nature of this in the illicit drug policy arena. Other themes discussed in this chapter include: the question of who was best placed to represent the interests of users in partnerships; the impact that the dominant prohibitionist discourse has on the effectiveness of user involvement in partnerships; a sense among ‘partners’ that a “new moral discourse” is evident in drug policy and treatment; and the silencing of dissent that is used as a means of further disempowering an already marginalised group.

The final chapter summarises the key findings of the research and reiterates the view expressed by many of the interview participants that the concept of partnerships is largely a rhetorical tool used by neoliberal forms of government to convey a sense of inclusiveness in policy development and service delivery planning processes. In this chapter I also discuss possible alternative models that have been proposed in recent years that adopt a more rational approach to the issue of drug consumption and drug related harms.

Chapter 2 - Governmentality and Illicit Substance Use

2.1 Introduction

In this chapter I argue that a theoretical framework of governmentality provides a sophisticated understanding of contemporary approaches to illicit drug use in neoliberal societies. I outline how I interpret various theoretical perspectives on governmentality and define how I use key aspects of these in my analysis of illicit drug policy. I also provide an overview of Foucault's theory of biopower and contend that it remains a relevant theoretical concept for understanding illicit drug policy as it operates in Australia today. Finally I suggest that harm minimisation is a neoliberal enterprise that can be situated within a governmentality framework of analysis and contribute to understanding contemporary policy responses to substance use.

This is the first of two chapters outlining the theoretical framework I adopt in my analysis. The subsequent chapter identifies further defining features of contemporary neoliberal responses to illicit substance use that can also be situated within a governmentality framework, particularly in relation to partnerships involving people who use illicit drugs. In both these chapters I propose that in order to better understand these responses additional theoretical perspectives also need to be considered in order to augment a governmentality framework of analysis.

2.2 Why Governmentality?

In the following section of this chapter I argue why I consider governmentality a suitable framework for analysing the question I pose in the research. The link between Foucault's theories on technologies of social control in works such as *Birth of the Clinic* (1973) and *Discipline and Punish* (1991) and his later work on 'technologies of the self' such as the three volumes of the *History of Sexuality* (Foucault 1984b, 1990, 1998) only came to be recognised with the publication of his lecture titled *'Governmentality'* (Foucault 1994a; Lemke 2002; Petersen 1997; Turner 1997:198). Foucault argued that governmentality should not be regarded as having replaced a disciplinary society but rather, along with sovereignty, that it should be seen as

constituting a triangular form of power focusing on the whole population and having various apparatuses of security as their essential mechanism (Foucault 1994a; O'Malley 1996; Turner 1997). Turner argues this provides a 'bridge between Foucault's early historical interest in regimes of discipline and his later work on the production of the self' (Turner 1997:xi). This 'bridge' makes governmentality a useful framework for analysing the functions of the health and welfare professions and how the state mobilises its power and utilises expertise in formulating policy responses to substance use to help shape the 'conduct of conduct' – a key concern for governmentalitists. This 'bridge' also seeks to overcome the conflict/consensus and agency/structure binaries that are a common feature of contemporary sociological analysis.

Lemke argues that governmentality is a key to Foucault's 'analytics of power' for the following reasons

> It offers a view on power beyond a perspective that centers either on consensus or on violence; it links technologies of the self with technologies of domination, the constitution of the subject to the formation of the state; and finally, it helps to differentiate between power and domination (Lemke 2002:51).

Foucault's development of the theory of governmentality is said to have been an attempt to challenge contemporary Marxist concepts of power as an overarching macro-structure (Petersen 2003; Turner 1997) 'intent on maximising power and seeking to constrain the liberty of its citizens' (Lupton 1995:9). Instead Foucault's work identifies power as much more local and dispersed, 'emerging not necessarily from the state but from all areas of social life' (Lupton 1995:9) and operating through notions of liberty, freedom and 'active citizenship' (Dean 1995, 1999; Lupton 1995; McKee 2009; Turner 1997). Similarly, Gordon (1994) suggests that not only did governmentality challenge Marxist but, also, Freudian concepts of power as a repressive and forbidding force. Instead Foucault's work identified power as much more local and dispersed, infused throughout the social system, utilising a range of practices but also having a productive and positive influence (Gordon 1994:xix;

O'Malley et al. 1997:506; Petersen 2003; Rose and Miller 1992). Further, Lupton (1995) argues that 'governmentality avoids the notion of the state as an overarching, coherent, repressive authority' (1995:9) that distinguishes it from Marxist perspectives which I consider makes it a more useful theoretical framework for understanding the policy approach of 'partnerships' in regard to substance use. This is not to say that Foucault's theory of governmentality was completely at odds with Marxism: indeed Lemke (2002) suggests that governmentality resembled a 'tactical alliance' with 'some concepts compatible with Marxism' (2002:49). However, it has been argued that unlike Marxism, governmentality avoids dealing in high levels of abstraction about the capitalist modes of production and instead focuses on the more mundane practices of rule and institutional programs and practices at the everyday level (Weir et al. 1997:503). For the purposes of my analysis this has a particular resonance, especially in regard to the practice of partnerships involving people who use illicit drugs.

Governmentality has 'an intellectual proximity to Max Weber's study of instrumental rationality and bureaucracy' as well as 'parallels to Goffman's notion of the total institution' (Turner 1997:xvii). Governmentality has been described as

> a mechanism for regulating and controlling populations through an apparatus of security. This governmental apparatus required a whole series of specific *savoirs* and was the foundation for the rise of the administrative state (Turner 1997:xiii).

These *savoirs*, or 'know-how' (Gordon 1994:xvii), are dispersed throughout the social body and specific forms of power require particular forms of knowledge. The concept of governmentality acknowledges 'the complexities, subtleties and micro-negotiations of relations of power' (Petersen 1997:203). When analysing the development of drug policy and treatment services it is important to identify the various locations and networks of power/knowledge that are brought into play as part of this process.

Governmentality has become a key concept in the sociology of health in recent decades (Turner 1997). Power and knowledge are fundamental aspects of a

governmentality approach to analysing the practice of public health, where governing the health of populations involves negotiations around the exercise of power and is inextricably linked with the production of expert knowledge about various aspects of the health of the population (Bunton 2001; Lupton 1995; Petersen and Lupton 1996). What is of interest to governmentality researchers is what knowledges count as authoritative and what discourses are adopted as 'truths' because of their efficacy in supporting government objectives (Gordon 1994:xviii). Truth, argued Foucault,

> is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of statements. "Truth" is linked in a circular relation with systems of power that produce and sustain it, and to effects of power which it induces and which extend it - a "regime" of truth (Foucault 1994c:132).

When analysing these 'regimes of truth' it is also important to identify discourses of discrepancy, or resistance, which is another objective of this research. Gordon argues that 'Foucault was always at pains to say that resistance is an endemic fact in the world of power relations' (Gordon 1994:xx). The continued use of proscribed substances, and the existence of organised groups of people who use them within a prohibitionist paradigm, are an exemplar of this. At the same time, the refusal by governments to acknowledge the failure of prohibition and continue with a 'war on drugs', in spite of an increasing body of evidence that this is a failed approach (Macintosh 2006; Rowe 2004a; Wodak and Moore 2002), can also be viewed as a form of resistance to rational evidence-based approaches to rule. While it is difficult to accurately quantify the direct costs of prohibition, it has been conservatively estimated that in Australia in 1998/99 it was in the vicinity of $2 billion (Macintosh 2006:33) and 'there is little doubt these costs have grown significantly since then' (Macintosh 2006:viii). The indirect costs are even more difficult to accurately quantify, and include increased violence and corruption, increased risk taking by users, and increased crime (Macintosh 2006). This prohibitionist approach also demonstrates resistance to an authentic liberal doctrine 'that regards the maintenance

of liberty as an end in itself and therefore sees it as setting limits to both the ends and means of government' (Hindess 2005:395).

Foucault viewed power not as a totally negative, repressive force but rather

> that it doesn't only weigh on us as a force that says no; it also traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network that runs through the whole social body, much more than as a negative instance whose function is repression (1994c:120).

Rose and Miller (1992) argue that power is

> not so much a matter of imposing constraints upon citizens as of making up citizens capable of bearing a kind of regulated freedom. Personal autonomy is not the antithesis of political power, but a key term in its exercise, the more so because most individuals are not merely the subjects of power but play a part in its operation (Rose and Miller 1992:174).

Gordon (1991) makes the point that Foucault believed there was 'a way for the governed to work with government, without any assumption of compliance or complicity, on actual and common problems' (Gordon 1991:48). Gordon cites Foucault on this perspective 'To work with a government implies neither subjection or global acceptance. One can simultaneously work and be restive. I even think that the two go together' (Foucault 1981 cited in (Gordon 1991:48)).

It is this perspective of power that I adopt in my analysis to better understand how peer-based illicit drug user advocacy groups have been established and fostered by (some) State and Federal Governments in Australia as a response to the harms related to illicit drug consumption within a dominant prohibitionist discursive environment. In this instance governmentality can be viewed as an enabling strategy that seeks to engage subjects, albeit subjects on the margins of civil society, in a productive manner as a means of reducing the harms associated with illicit drug use.

2.3 Critiques of Governmentality

In the following section of this chapter I discuss some of the critiques of governmentality and outline how my research approach addresses these concerns. These critiques, it should be noted, come mainly from those who would consider themselves 'governmentalitists' and seek to 'overcome the boundaries between the study of the intellectual dimensions … and the study of the messiness of human practices' (Stenson 1998:350). A governmentality framework, and the approach adopted by some of the leading proponents of this theoretical framework, has been criticised for focusing too much on abstract notions of political rationalities and technologies of rule and has failed to adequately develop a critical politics that analyses how they function in practice (Garland 1997:200; Petersen 2003). As a result this has led to a tendency to overlook the 'messy actualities' of social relations (O'Malley et al. 1997:509; Petersen 2003) which has been argued to weaken the diagnostic value of governmentality studies and 'limited their potential to contribute to change' (Petersen 2003:197). Another criticism is a perceived tendency to view government programs 'as if they are written by one hand, rather than … multivocal, internally contested and thus, in a sense, always in change and often internally contradictory' (O'Malley et al. 1997:513). This research avoids this tendency by looking at the contested nature of drug policy, the expert bodies entrusted with formulating these policies and the role of user advocacy organisations in partnerships.

Another criticism of governmentality accounts of liberal forms of government was that the 'significance of partisan politics for liberal reflections on government is hardly acknowledged' (Hindess 2005:396). The implications of electoral politics for liberal government are not adequately accounted for in Foucault's discussions of the state and fail to address the 'partisan promotion of sectional interests and values, including disputed conceptions of the common interest itself' (Hindess 2005:397). The lack of attention paid by governmentality scholars to 'counterdiscourses, contestations, and resistances or to see these only as sources of programmatic failure' (Petersen 2003:197) is another criticism that has been made of a governmentality approach.

This failure to adequately account for politically oriented action is considered by Hindess (2005) to be a significant limitation of governmentality analyses of liberal forms of government. The 'neglect in governmentality studies of strategies and practices of government initiated from 'below'' (Stenson 1998:348) is considered another shortcoming of the focus on political rationalities and technologies of rule of governmentality studies. Stenson (1998) makes a point about the neglect of these strategies and practices initiated from 'below' that is pertinent to this research. He argues that 'given they [various agencies and networks] are increasingly enrolled in 'partnership' initiatives in the struggle to govern' (1998:348), that a 'failure to recognize the significance of these groupings as creative agencies of governance in their own right, is to risk lapsing back into a 'top down', state centred view of government' (Petersen 2003; Stenson 1998:349). Again this research avoids this perceived limitation by focusing on the role of people who use illicit drugs in partnerships.

McKee (2009) also noted limitations in the way a governmentality approach has been adopted by 'post-Foucauldian' social policy analysts. McKee argues that governmentality has been criticised for 'its disregard of empirical reality' (2009:473) due to a focus on discourse as opposed to a 'social realist' approach to policy analysis. McKee perceives a tendency to focus on government documents which has resulted in 'a disconnection between the study of specific mentalities of rule and the social relations in which they are embedded' (2009:473). She sees this as posing problems for understanding 'the effects of power at the micro-level and the lived experience of subjection' (2009:474). It also ignores the fact that

> political authorities remain in control of both policy agendas and significant financial resources, with community participation occurring in strictly defined parameters. This is more akin to a process of incorporation than empowerment, and results in strategic-level decisions being retained within the state apparatus (2009:475).

McKee proposes a strategy for overcoming this is to adopt a 'realist governmentality' approach by 'complementing discursive analysis of emergent governmentalities with

localized empirical accounts of actual governing practices' (2009:478). This involves using ethnographic approaches alongside analysis of government policy documents to show how policies actually play out in the real world. Such an approach can illuminate 'the contingent and particular national, sub-national and micro-level factors that may shape universalistic governmental rationalities' (2009:480). It is with this in mind that I have elected to incorporate a Critical Discourse Analysis approach of various government texts with an ethnographic study of members of partnerships involving people who use illicit drugs in my research. This dual approach 'opens up a critical space in which to explore how central 'plans' are mediated from below and the way in which projects of rule are applied differently in different places' (2009:480). This is particularly relevant for one of the key aims of my research in which I analyse factors that have contributed to the failure to establish a viable and sustainable illicit drug user advocacy organisation in Tasmania, while such organisations have prospered in other States. Having outlined some of the major critiques of a governmentality approach in the following section I discuss some of the challenges and opportunities that such an analytical framework poses for my research.

2.4 The Challenges and Opportunities of a Governmentality Framework

Foucault's concept of governmentality has evolved over time and given rise to a diverse corpus of literature with no agreed definitions or methods (Dean 1999: 4). As Rose (1994) notes: nothing would be more counter-productive than an attempt to crystallize a 'methodology' from Foucault's studies, a recipe that could then be 'applied' to diverse topics' (Rose 1994:50). Similarly, Petersen states 'there is no consensus about a "correct" methodology' (2003:191) in regard to analytics of the mentalities and rationalities of government. Petersen goes on to argue that 'governmentality work does not offer a ready made set of hypotheses or theories that can be applied to an existing set of issues or problems' (2003:193). This makes the utilisation of a governmentality framework of analysis challenging on the one hand, but opens up a realm of possibilities on the other. The challenge lies in the necessity to selectively adopt particular aspects of such a burgeoning perspective. This could

place the research at risk of having too narrow a focus and not adequately addressing the complexities of the concept.

The opportunities of adopting such a framework of analysis do, however, provide the researcher with a certain degree of freedom. As Foucault himself had not really developed the concept of governmentality to any significant extent it has been interpreted and utilised in such a diverse manner as to open up a range of possibilities not constrained by any orthodoxy. It also offers the opportunity to provide new insights into the 'assemblage of practices, techniques and rationalities for shaping the behaviour of others and oneself' (Dean 1999:198) and add to the considerations necessary when trying to make sense of these in relation to partnerships with people who use illicit drugs in a discursive environment of prohibition.

2.5 Possible Alternative Theoretical Approaches

Having discussed what I consider the strengths and weaknesses of a governmentality framework for analysing the practice of partnerships involving people who use illicit drugs, in this section I briefly discuss alternative approaches I could have adopted in my analysis and argue why I consider a governmentality approach to be of greater utility for the purpose of my research. These alternative approaches are the Advocacy Coalition Framework (ACF) developed by Sabatier (1987) and social movement theory.

The ACF approach theorises the policy process as a struggle between various coalitions and individual actors with competing beliefs systems and values about policy problems and possible solutions. Social movement theory aims to 'provide an analysis of social change that focuses on collective actors as the major driving force, without assuming *a priori* that institutions, political parties or other formal organizations play the central role in these processes' (Kubler 2001:627)

The ACF approach has been applied to an analysis of Australian drug policy between 1980 and 2000, and was found to be an 'adequate' framework of analysis for explaining what Hallam (2006) described as the 'rise and stall of harm minimisation'

(2006:iii). However, she argued that the ACF theoretical lens was more appropriate for analysing policy processes in 'natural systems', such as those relating to environmental issues, than in 'social systems' such as in the field of drug policy (Hallam 2006:53). The ACF approach has also been applied to an analysis of Swiss drug policy and was found to facilitate an understanding of policy changes that led to the introduction of drug injecting rooms and heroin maintenance programs in Switzerland. However, Kubler (2001) argued the ACF approach had some limitations regarding collective action and mobilising structures which prompted him to incorporate elements of social movement theory to augment what he considered shortcomings of the ACF and 'help to comprehend coalition emergence, persistence, strategies and success' (2001:624).

Kubler contends that social movements 'can be understood as the mobilization of protest against particular aspects of the social order, or the (expected) results of particular policies' (2001:627). He argues these mobilising structures are based on three key principles: the potential interpersonal benefits from ongoing participation in an organised group or association; the various resources that can be shared through collective action; and the cognitive benefits derived through participation in such movements (2001:628). Another important consideration is that 'a movement needs to build arrangements to direct its affairs, and notably the flow of resources to members facilitating their engagement for the common cause' (2001:628). Finally, Kubler argues, it is important to consider the 'political opportunity structure' and the institutional structures and macro-political environment in which social movements form and thrive or, in some instances, fail (2001:629).

This potentially makes either of these two theoretical frameworks suitable for explaining illicit drug user advocacy organisations. These frameworks also have some utility for understanding the formation of organisations such as the International Harm Reduction Association (IHRA) and the Australian Drug Law Reform Foundation (ADLRF). These organisations involve people who use illicit drugs, health professionals and researchers (among a range of other 'experts') in advocating for an end to the current dominant discourse of a prohibitionist approach to drug use. These

frameworks could perhaps be gainfully employed for analysing the existence of user organisations in NSW and Victoria, which have been operating for twenty years of more, or indeed the national user organisation the Australian Injecting and Illicit Drug Users League (AIVL). However, given the absence of any peer-based drug user advocacy organisation in Tasmania (either formal or informal) that could be analysed under a social movement framework, as well as a lack of influential advocates or coalitions calling for any change to the current policy approach in Tasmania that could be analysed using an ACF approach, I consider a governmentality approach more appropriate for the purpose of my research into the practice of involving people who use illicit drugs in partnerships. In the following section I elaborate on this point.

2.6 Defining a Governmentality Approach

In this section I provide an overview of the concept of governmentality as I utilise it in my analysis and argue that it is a useful framework for understanding the neoliberal enterprise of partnerships involving people who use illicit drugs. Foucault described governmentality as the

> ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security (1994a:219-220).

Government was considered by Foucault as 'a "contact point" where techniques of domination – or power – and techniques of the self interact' (Burchell 1996:20) and can be summarised by the phrase the 'conduct of conduct' (Dean 1999:10; Gordon 1991:48; Lemke 2002:50; Rose 1999:3) which Dean describes as

> any more or less calculated and rational activity undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seeks to shape conduct by working through our desires, aspirations, interests and beliefs for definite but shifting ends

> and with a diverse set of relatively unpredictable consequences, effects and outcomes (Dean 1999:11).

Government in this sense means not only the common perception of the sovereign state, but also operating at the level of the individual – as in the term self-conduct. In between are a myriad of levels of governmental regulatory sites such as the workplace, the household, the classroom and community based organisations (Dean 1996:223; 1999:10; Lemke 2002:50; Lupton 1995:9).

In seeking to explain what is meant by the term governmentality Dean (1999) suggests that it has two broad meanings. The first relates to 'how we think about governing, with the different mentalities of government' (1999:16) with these 'mentalities of government' providing the origins of this concept. The second meaning relates to the emergence of liberalism in Western societies and 'a distinctly new form of thinking about and exercising of power in certain societies' (1999:19), as well as a new form of governing 'bound up with the discovery of a new reality, the economy, and concerned with a new object, the population' (1999:19).

Tyler argues that the term governmentality was used by Foucault to describe the emergence of an 'art of government' organised around the maximisation of the capacities of the resource of a state's population, and of technologies which make it possible for population as a resource to enter into the realm of political rule (Tyler 1997:78). Gordon, defining what is meant by the term 'art of government', explains it as

> a way or system of thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed), capable of making some form of that activity thinkable and practicable both to its practitioners and to those upon whom it is practiced (Gordon 1991:3).

These rationalities are said to be integral to our 'ways of thinking about and acting upon one another and ourselves' (Barry et al. 1996:7).

In the health field they include a complex apparatus of technologies that focus on the task of managing individuals and the wider social body as a vital national resource. These rationalities seek to address an array of health issues through the interventions of an assemblage of 'experts' such as doctors, pharmacists, social workers and counsellors. Governmentality can then be seen as a way of 'problematising' life and seeking to develop and deploy a range of mechanisms and devices for acting upon it (Rose 1993). In this way government seeks to link various state-sanctioned authorities with those over whom their authority is to be exercised. This further extends the networks of surveillance in the social body, serving to increase the capacity to gather a range of information about the population being governed.

Foucault argued that the essential issue in the establishment of the 'art of government' was 'the introduction of economy into political practice' (Foucault 1994a:207). Governmentality then means the application of the principles of economics at the level of the entire state, exercising a form of surveillance and control over the resource of population in order to guide the 'conduct of conduct'. A governmentality approach requires the development of a range of technologies to support the administrative structures of the state to facilitate this surveillance. In contemporary health systems these technologies include the development of a range of information systems, not only relating to clinical and epidemiological information but also financial information systems to monitor health expenditure. It also requires the establishment of numerous 'expert bodies', typically comprising a range of medical and allied health professionals, bureaucrats and increasingly, in some areas at least, consumers, to oversee policy development and service delivery planning processes. It is this concept of involving consumers in drug policy development and service delivery planning processes that is the key focus of my analysis.

2.7 Governmentality, Liberalism and Neoliberalism

In this section I describe how governmentality emerged under liberal forms of government, and in more recent years has been refined with the emergence of neoliberalism. I discuss how liberal forms of government have utilised 'experts' to

facilitate a more efficient form of governing subjects consistent with liberal principles of freedom and autonomy.

The rise in expert knowledge of human conduct is a key aspect of Foucault's concept of governmentality. This entails the pursuit of 'rational' technologies of government through which a variety of experts and authorities sought to implement a range of projects in relation to available resources, calculating both the benefits and risks of such projects. These 'expert systems' cover a broad range of fields including economics, business practices and 'the management of human misery' (Rose 1993:284). Under 19th century liberal forms of government expert authority became intrinsically linked with the formal political apparatus. The political apparatus invested a variety of expert bodies with the authority to act on its behalf in establishing acceptable norms of conduct. This enabled populations to be governed in a more indirect manner, ostensibly providing a greater level of individual freedom. Neoliberalism, on the other hand, has sought to utilise expertise in a different way. By seeking to detach these experts from the political apparatus, to some extent at least, and situate them 'within a market governed by the rationalities of competition, accountability and consumer demand' (Rose 1993:285), neoliberalism sought to further define the boundaries between state and civil society (Bunton 2001). In order to understand contemporary drug policy from a governmentality perspective it is critical to identify these various technologies and expert bodies and seek to situate them within the social and political milieu in which they have been developed. The Australian National Council on Drugs (ANCD) is one such expert body established by former Prime Minister Howard that is discussed in more detail in the following chapters.

Liberalism's basic philosophy seeks to limit the scope of political authority while fostering the freedom and autonomy of its subjects. This has been fundamental in shaping government rationalities in contemporary Western societies. Liberalism had a number of defining features including: a new relation between government and knowledge and an inherent relation to the authority of experts; a specification of the subjects of political authority as active in their own government; and a continual

questioning of the activity of government itself (Burchell 1996; Dean 1999; Hindess 1996; Rose 1993, 1996a). These key features of liberalism connect the activity of government with a range of expert knowledges that seek to make these activities more effective, while at the same time aspiring to shape individuals who are capable of governing themselves. This serves to create divisions between responsible citizens and those considered lacking the capacity to exercise their citizenship fully, such as people who use illicit drugs. Such groups of people are deemed to be inadequately socialised into the wider norms of acceptable behaviour and are subjected to a form of 'authoritarian liberalism' that I discuss in more detail below. This necessitated political forces to engage a range of 'experts' such as doctors, social workers and psychologists from outside the formal state apparatus to enable the state to 'govern at a distance' thus reducing the likely negative impact on the wellbeing of the broader population. Finally, the continual evaluation of the effectiveness of various interventions, and their impact on the efficacy of government, leads to a constant search for ways to govern better. This, however, posed a dilemma for liberalism: the tension between not governing enough versus governing too much (Burchell 1996; Rose 1993, 1996a; Rose and Miller 1992).

According to Rose (1993, 1996a, 1999) neoliberalism emerged largely in response to a perceived failure of 'welfarism', a key project of liberalism. Welfarism sought to address the shortcomings of liberal government by putting in place a range of social insurance measures to guarantee the collective security and wellbeing of the state. Neoliberalism criticised welfarism as being too costly, inefficient, overly interventionist and, more importantly, as undermining personal autonomy through developing a mentality of dependency (Burchell 1996; Fraser and Valentine 2008; Hindess 1996). Neoliberal forms of government are said to have a number of defining features that distinguish it from liberalism, including a redefined relationship between expertise and political authority and a new specification of the subject of government (Bunton 2001; Rose 1993, 1996a). The relationship between expertise and political authority under welfarist models led to the development of 'expert enclosures' in which the authority of expert knowledge could not be challenged, thereby insulating it

from attempts by political authorities to govern it. Under neoliberalism these enclosures were permeated through a range of techniques, such as contractualism, marketisation and auditing, that enabled them to be subject to greater scrutiny by political authorities. Another feature of neoliberalism, the redefined subject, sees individuals as now obliged to adopt a more calculative relationship to risk and danger and to exercise greater choice as a consumer of services provided by experts (Bunton 2001; O'Malley 1996; Rose 1993, 1996a, 1999). It is in this context that I analyse the concept of partnerships with people who use illicit drugs.

Governmentality and its emphasis on rational, calculative approaches to rule thus gave rise to an increased focus on risk management, sometimes referred to as actuarialism (O'Malley 1996). O'Malley argues this approach to managing social problems is considered more rational than overt force as it serves to increase the effectiveness of power while recognising that it is easier than modifying individual behaviour. Furthermore, actuarial technologies are considered to be less likely to generate resistance, as they tend to be covert techniques of social regulation. The proliferation of disciplinary and actuarial technologies in the health field, such as pharmacotherapies for treating opiate addiction, is the outcome of contested and negotiated political programs that seek to adopt a variety of techniques considered appropriate for the problems they seek to ameliorate. Hence they are also seen to be more efficient in terms of a political and economic cost-benefit analysis (O'Malley 1996).

Neoliberal advocates of a risk-management approach to social problems contend that welfarist models served to undermine the efficiency of populations. This could only be addressed by the introduction of free-market principles and refocusing on rational actors adopting individual initiative and entrepreneurialism. This, it is argued, provides the spur for individuals to manage their own risks by removing the notion of collectivist risk management approaches. This approach has been described as prudentialism as it fits better with the free market environment (O'Malley 1996). This neoliberal ideology has had a significant impact on developments in a number of areas of contemporary social policy. One such example of the rise in neoliberal

prudentialism can be found in the health sector and the retreat from publicly provided services. This has occurred alongside a concomitant promotion of private health insurance schemes whereby individual consumers are said to be 'free' to choose the services they wish to purchase. Alongside this is a burgeoning array of programs that emphasise the importance of a disciplinary body regime aimed at maintaining and improving the individual's health status. This is based on the notion that the rational, calculating individual will make prudent lifestyle choices based on a discursive construction of moral responsibility to care for the self, both in the interests of individual wellbeing and for the benefit of the wider social body (O'Malley 1996). The dividing practices of neoliberalism, however, make distinctions between individuals considered fit to bear the freedoms and responsibilities of citizenship and those for which another form of governance is deemed necessary, that of authoritarian or 'despotic' liberalism, which I discuss in the following section.

2.8 Authoritarian Liberalism – 'Governing the Margins'

Liberal forms of government regularly use techniques for identifying individuals who 'are capable of bearing the freedoms and responsibilities of a citizen and those who, for whatever reason, are deemed not to possess the characteristics necessary for such a task' (Dean 1999:135). It has been argued that 'authoritarian rule has always played an important part in the government of states that declare themselves to be committed to the maintenance and defense of individual liberty' (Hindess 2001:94; 2005:402). Liberalism is 'concerned with the government of numerous individuals and significant areas of conduct that seem not to be amenable to available techniques of governing through freedom' (Hindess 2005:402). Individuals who behave in a manner not deemed prudential are considered as failing to meet their obligations as responsible 'active' citizens (Osborne 1997; Petersen 1997:198). This enables government to make distinctions 'between the civilized and the marginalized' (Dean 1995:580) who are 'sanctioned by exclusion' (Bunton 2001:224). These marginalised groups are not considered affiliated with communities of active, responsible citizens

> by virtue of their incapacity to manage themselves as subjects or they are considered affiliated with some kind of 'anti-community' whose morality, lifestyle or comportment is considered a threat or a reproach to public contentment and political order (Rose 1996c:340).

This necessitates the deployment of coercion and legal sanctions (Dean 2002:40) to bring about desired ends among members of such 'anti-communities'.

Individuals whose 'conduct falls below the civilized norm must be subjected to improvement through more or less extended periods of discipline before they can sensibly be left to manage their own affairs' (Hindess 2001:104), a process described as 'the government of unfreedom' (Hindess 2001:94). This has also been described as 'illiberal moral regulation [and] 'despotic' moral governance' (Valverde 1996:359) and leaves those deemed unfit to 'govern through freedom' (Rose 1999) open to a range of judicial and welfare sanctions (Dean 1995; Wodak et al. 2004), often with a strong moral undertone 'justified by a neoconservative discourse of just desserts and retribution' (O'Malley and Mugford 1991a:127). However it has been argued that

> far from being a simple matter of liberal hypocrisy, of denying its commitment to liberty, the resort to authoritarian rule in certain cases is a necessary consequence of the liberal understanding of that commitment (Hindess 2001:94).

Similarly, it has been argued that such 'despotic' forms of governance are a common feature of classical liberal political discourse (Hathaway 2002; Valverde 1996). This is based on a belief that liberal forms of governments

> can specify the kinds of freedom and autonomy that are to become the objectives of governmental policies and practices and which, under certain circumstances, will require the use of instruments of coercive authority (Dean 2002:40).

People who use illicit drugs, and peer-based organisations that represent their interests, form part of the 'anti-community' described by Rose above. Fraser and

Valentine (2008) argue that people 'dependent' on methadone 'occupy an invidious relationship to the normative 'participating' worker citizen and proper liberal subject' (Fraser and Valentine 2008:13) making them part of this 'anti-community'. It is this concept of authoritarian liberalism that makes the practice of partnerships in policy development and service delivery planning processes particularly challenging, as I discuss in more detail in following chapters, and makes the practice of an 'ideal governmentality' approach a significant challenge.

2.9 Defining Key Components of Governmentality

In the previous section I discussed how liberal forms of government have accommodated authoritarian approaches in order to govern populations, particularly those considered on the margins of civil society. In this section I elaborate on two key aspects of governmentality that I utilise in my analysis of partnerships involving people who use illicit drugs. As discussed above, two key components of a neoliberal governmentality approach are the concepts of 'governing at a distance' and 'technologies of the self' which I consider critical for understanding the involvement of people who use illicit drugs in policy development and service delivery planning processes. The contact point between these two levels of government is fundamental to the effective control of populations in neoliberal regimes. A clarification of how I utilise these two concepts follows below.

2.9.1 Governing at a Distance

The notion of 'governing at a distance' is consistent with liberal and neoliberal principles of limited government and conveys a sense of free will and liberty among citizens (Gordon 1991; Rose 1999; Rose and Miller 1992). This has been described by Nikolas Rose as 'governing through freedom' (Rose 1999). Rose and Miller (1992) argue that a key task for liberal forms of government is to identify and promote 'civil society', a domain that is regarded as external to politics, and seek to manage it without compromising its autonomy. In order to achieve this it must forge a series of alliances, or partnerships, with a diverse range of experts outside government (Rose and Miller 1992:180).

In regard to health policy, the delegation of authority by the state to the biomedical sector can be considered an example of 'a liberal art of government that legitimates a medical profession in the interests of an indirect government of health' (Osborne 1997:183). In this way government is perceived to be not directly involved in health matters but is involved indirectly, 'at a distance', through state sanctioned experts. Indeed, Rose (1999) argues that liberal forms of government are 'inextricably bound to the activities and calculations of a proliferation of independent authorities – philanthropists, doctors, hygienists, managers, planners, parents and social workers' (Rose 1999:49). These 'technologies of government link a multitude of experts in distant sites to the calculations of those at a centre' (Rose 1999:50).

As discussed above, Rose (1999) argues that a minority of 'anti-citizens', such as people who use illicit drugs, 'remain outside this regime of civility' (1999:89) and are criminalised through their consumption choices. Rose argues that this opens up a new 'territory of the marginalized' (1999:90) where expertise operates through 'a range of new para-government agencies – charities, voluntary organizations supported by grants and foundations … as well as a multitude of 'for-profit' organizations receiving funds from both state and private sources' (1999:90). He describes how this confers upon lay workers a certain expertise normally eschewed in civil society where expert regimes are valorised. This then opens up opportunities to work with marginalised groups and so inscribe upon these margins a distinctly new type of 'government at a distance'. This can be a risky approach due to the 'reliance upon those who are able to mobilize around the power to speak the truth and the capacity to act knowledgeably upon conduct' (Rose 1999:51). This is where government funding to peer-based drug user advocacy groups is an inherently risky strategy, a topic I discuss in more detail in the following chapter. But it is also this desire to govern through the unique expertise of people who use illicit drugs and their representative organisations, utilising the 'specific intellectual' (Foucault 1994c:129), that a neoliberal rationality of 'governing at a distance' is evident.

2.9.2 Technologies of the Self

The concept of 'technologies of the self' refers to any self-care regime such as diet, exercise, meditation or ritual aimed at producing better physical and emotional health and wellbeing embracing 'the ways in which one might be urged and educated to bridle one's own passions, to control one's own instincts, to govern oneself' (Rose 1999:3). Foucault describes these practices of the self as 'intentional and voluntary actions by which men[1] not only seek to transform themselves, to change themselves in their singular being' (1984b:10-11). Dean suggests 'government encompasses not only how we exercise authority over others, or how we govern abstract entities such as states and populations, but how we govern ourselves' (Dean 1999:12). Elsewhere Dean (2007) describes technologies of the self as

> life becomes a 'planning project' in the sense that the individual must plan and become the 'head office' of her or his own life and that it is up to the individual to make informed choices about life itself (2007:193).

Individualism is actively promoted within neoliberal discourses as it portrays subjectification as a voluntary, self-directed exercise that provides a notion of freedom and autonomy (Bunton 1997; Fraser 2004; Lupton 1995; Petersen 1997; Rose 1996b). A great deal of the literature on governmentality in the health arena concerns both the subjection and subjectification of individuals, often focusing on the responsibilised, enterprising, risk-calculating, 'active citizen' whose prudent behaviour and self-care are considered to have flow-on benefits for the wider community (Dean 1996; Fraser 2004; Garland 1999; Nettleton 1997; O'Malley 1996; Rose 1999).

An example of 'technologies of the self' as it relates to people who use illicit drugs can be found in an analysis of health promotion resources for hepatitis C (HCV) prevention targeting people who inject drugs. Fraser (2004) argues that their contents typically reflect a neoliberal governmentality view of the primacy of the individual

[1] Foucault's language had a tendency to be androcentric.

actor, and their role in making prudent choices in relation to the risks involved in injecting. The enterprising, risk-calculating individual is identified as a common feature in the HCV prevention materials, with little attention paid to the social or political structures that impact on an individual's capacity to adopt safer injecting practices. Many of the resources analysed by Fraser focus on 'explicit behaviour modification' and 'individual vigilance' (2004:202) in order to protect oneself from contracting HCV consistent with Foucault's notion of 'care of the self' (Foucault 1990).

Many of the HCV prevention resources analysed by Fraser (2004) also invoke a responsibility to care for others. This includes not only other people who inject drugs but also the wider public for whom the issue of inappropriately discarded injecting equipment is a major concern. Fraser argues that the messages in a number of the resources not only urge people who inject drugs to care for themselves and others through the use of new injecting equipment but also urge them to promote such practices among their peers. Viewed from a governmentality perspective, adopting appropriate 'technologies of the self' can be seen to have benefits for the wider community (Fraser 2004). This again underlines the utility of a governmentality framework of analysis for understanding the concept of partnerships and the desire to 'govern at a distance' in the illicit drug field. In the following section I discuss some of the contradictions evident in neoliberal approaches to substance use and how prohibitionist and pathologising discourses compromise fundamental liberal tenets of 'governing at a distance' and 'technologies of the self' as discussed above.

2.10 Contradictions of Neoliberalism and Drug Consumption

In this section I argue that the continued prohibitionist 'war on drugs' approach adopted in most contemporary neoliberal consumer societies is notable for its inherent contradictions. The process of pathologising substance use within modern neoliberal societies is at odds with the concept of 'freedom, autonomy and choice associated with the spread of consumerism' (Reith 2004:283). Reith argues that at the same time

as consumerism is promoted on a global scale it coincides with a growing fear of dependency and that 'the consumer might not be free after all' (2004:297).

Among the key pieces of Foucault's later work was the second volume of the History of Sexuality *'The Use of Pleasure'* (1984b). This work focuses on pleasure as a 'technology of the self', however, contemporary governmental discourses on drug use fail to recognise this as a possibility among responsible 'active' citizens, instead seeing it as a surrender of individual freedom. Neoliberal discourses on drug consumption fail to acknowledge the fact that, for the most part, drug use is a pleasurable experience (Bunton 2001; Coveney and Bunton 2003; Duff 2004; Hathaway 2002; Macintosh 2006; Moore 2008; O'Malley and Mugford 1991b). Most neoliberal government discourses on drug use 'remain silent about pleasure as a motive for consumption, and raise instead visions of a consumption characterized by compulsion, pain and pathology' (O'Malley and Valverde 2004:26). Further, Coveney and Bunton (2003) argue that neoliberal discourses on drug use afford 'little, if any, space for the pleasures of intoxication. Rather there was a 'systematic silencing' by discourses that pathologize the practice of alcohol and drug use' (2003:171). This neoliberal discourse on drug consumption is based on an 'elective affinity between freedom, good order and pleasure, and between disorder, compulsion and pain' (O'Malley and Valverde 2004:27) that are central to governmental visions of freedom and autonomy.

The prohibitionist-pathologising discourse also ignores the notion of commodification (O'Malley and Mugford 1991b), another defining feature of neoliberal societies. This phenomenon has seen illicit drugs such as cannabis and ecstasy 'marketed' to consumers under a plethora of different 'brands', as well as giving rise to new means of production using new technologies such as hydroponics. O'Malley and Mugford argue that 'in modern capitalist societies, there has been a steady growth over the last two centuries in markets for pleasurable commodities and that drugs, linked to this trend, need to be thought of in this way' (1991b:51). Elsewhere it is argued that in consumer societies individuals develop their identity through their consumption of commodities, and drugs are just one of these commodities (O'Malley and Mugford

1991b:57; Van Ree 2002:351). In arguing for the need to incorporate the use of pleasure into discourses relating to drug use, O'Malley and Mugford contend that 'drugs *epitomize* modern culture rather than being the aberration that the War on Drugs suggests' (1991b:53 emphasis in original). Coveney and Bunton argue that 'patterns of drug use would appear to mimic more general shifts in the consumption of goods and services under the influence of consumer society' (2003:172). Similarly, Van Ree posits that it is 'only natural that a society with a powerful consumer ethos develops an interest in drugs' (2002:351). In discussing the apparent contradictions between a prohibitionist-pathologising discourse and the subjugated discourse of drug use as a form of leisure in consumer society, O'Malley and Mugford argue that

> modern society can be understood to contain a complex and possibly contradictory relationship between the production-centered ethic that constructs the self through discipline, control, work, "clock time", deferred gratification, and calculative rationality, and a consumption-centered hedonistic ethic that encourages the pursuit of selfhood through self-expression, leisure, consumer goods, and pleasure (1991b:56).

In a world full of seductive invitations to consume for the sake of pleasure/leisure, a 'dream world' occupied by (or preoccupied with) the enticement of up-market shopping malls and luxury holiday resorts, it seems only natural that the consumption of drugs for purely pleasurable purposes results from this commodification of leisure and pleasure (Van Ree 2002:351-2). Furthermore, Macintosh has argued that the loss of pleasure that people would derive from substance use is not factored in to estimates of the costs of prohibition (2006:33-34). Again this highlights the inherent contradictions in neoliberal approaches to drug use in a globalised consumer society. No distinction is made between pleasurable use and problematic misuse, at least with illicit drugs, and the dominant prohibitionist-pathologising discourse considers all illicit drug use as dysfunctional and a moral failing on the part of the user. As Coveney and Bunton point out 'public health seems to have overlooked the obvious point that people take drugs for the experience of pleasure, however socially defined' (2003:173).

Meanwhile governments support, and are heavily dependent on, the promotion of the potentially addictive and harmful leisure pursuit of gambling. This is particularly evident in Tasmania where concessions are granted and monopoly deals made with major gambling enterprises such as Betfair and Federal Hotels in return for significant tax revenues. Other contradictions evident in Tasmania include the relentless pursuit of forestry practices which divide the community while restrictive barriers remain in place that limit the potential of a hemp industry that could significantly reduce the demand for timber products. This is largely based on a fear that some of this hemp might be diverted to the illicit drug market, in spite of its low psychoactive drug content. At the same time a lucrative opium poppy industry earns significant revenue for the State's agricultural sector, currently estimated at nearly $60 million per year (Giddings 2010). Meanwhile, a substantial number of potentially fatal poppy 'capsules' are diverted to the illicit market from this crop each year (de Graaff and Bruno 2009).

Dandeker (1990) argues that in a globalised system of commodification 'the state is a separate political and administrative order, but is able to supervise market society through bureaucratic surveillance in ways quite unmatched by other types of society' (1990:34). However, the prohibition of a range of psychoactive drugs has created a market that defies governmental supervision and regulation (Macintosh 2006; O'Malley 1999a; TDPF 2010; Wodak and Moore 2002; Wodak and Owens 1996) while at the same time providing institutional support to promoting and fostering a legitimatised and regulated market in highly addictive prescription pharmacotherapies. This legitimised market of 'anti-citizens' enables the state to exercise a form of bureaucratic surveillance over those deemed not to have developed the necessary 'technologies of the self' through a process I describe as 'the pharmaceutical panopticon' that I discuss in detail in the following chapter. At the same time it fosters a parallel market controlled by 'drug entrepreneurs' who have the resources, technologies and resourcefulness to remain unsupervised and outside of the gaze of the surveillance networks Dandeker (1990) alludes to. This market of 'anti-citizens' creates its own assemblage of expertise through a complex apparatus of

medical, legal, and administrative networks further enabling 'governing at a distance'. This is consistent with a 'business friendly approach' to social policy (Shin 2000) whereby private practitioners in medicine, the various 'psy' disciplines (Rose 1996b) and law firms profit from the identification of those unfit to bear the responsibilities necessary to 'govern through freedom' (Rose 1999). This market of the 'margins' (Rose 1999) created by a prohibitionist approach appears less an error and more a calculated, rational approach which governments find 'useful for their own purposes' (Levine 2002:169).

Elsewhere it has been argued that prohibition has its roots in historical xenophobia and fear of 'the other' (Bourgois 2003; Bunton 2001; Coomber 1998; Manderson 1992, 1993; O'Malley and Mugford 1991b; Rowe 2001; Webster 1999). These views are contradictory to an enlightened liberal approach to rule based on rational, scientific calculation whereby the role of government is to maximise the utility of the resource of population, 'at a distance' and through 'freedom' (Rose 1999), in order to strengthen the state's economy, and is further evidence of the inherent contradictions within neoliberal approaches to substance use. It is in this discursive environment that the concept of partnerships involving people who use illicit drugs has failed to have any significant impact on efforts to reduce drug related harms and is why I consider a governmentality framework requires augmentation for understanding this situation.

2.11 Harm Minimisation as Governmentality

In the final section of this chapter I examine the neoliberal enterprise of harm minimisation as a response to substance use and argue that it can be situated within the concept of a governmentality approach to rule as described above. This then sets the background for my argument in the following chapter about a range of other factors that need to be considered when analysing contemporary responses to drug use.

Harm minimisation is a risk management approach typical of neoliberal governmentality approaches to rule. This approach recognises that there will always be some level of illicit drug use within a society, and the task of government is to

develop responses that minimise the harmful effects of this at the level of both the individual and the wider social body (Miller 2001; Mugford 1993). O'Malley (1999a) describes harm minimisation as a neoliberal project that seeks to make drug use 'thinkable in new ways … and thus made subject to new techniques of governance' (1999a:192), namely risk management and 'actuarialism'. Harm minimisation has been described as a critical component of the neoliberal enterprise of the 'New Public Health' (Zajdow 2004) that is discussed in detail in the following chapter.

Harm minimisation seeks to identify problematic behaviours and to mitigate or prevent the harms associated with such behaviours. Rather than focusing on individual risk behaviours harm minimisation casts its gaze on 'patterns and characteristics of aggregates and distributions' and situates individuals in terms of their 'membership of risk categories' (O'Malley 1999a:193). To achieve this it draws on a number of features of governmentality, including the use of expert knowledge, the use of a range of surveillance technologies, the use of technologies such as pharmacotherapies and the use of 'technologies of the self' (Zajdow 2004). And, as Miller (2001) has argued, the role of experts in developing and implementing harm minimisation initiatives extends 'the mechanisms of social control and medical dominance' (2001:168). Harm minimisation is also seen as

> a remedicalisation of addiction with a more diffuse control over the individual; instead of the single general practitioner or psychiatrist, many other health professionals retain control … it is also concerned with modifying the behaviours of those whose drug use is not necessarily addictive or problematic (Zajdow 2004:74)

Harm minimisation was adopted as the official policy approach to illicit drugs in 1985 but has remained an arena of fierce contestation, particularly since the Howard Government announced its "Tough on Drugs" initiative, and the 'discrepancy between rhetoric and action is evident in many different areas of drug policy' (Miller 2001:169). This is discussed in more detail in Chapter Five where I develop a genealogy of Australia's illicit drug policy and partnerships involving people who use illicit drugs and adopt a Critical Discourse Analysis approach to explain how this has

evolved. The Australian policy of harm minimisation adopts three key technologies to mitigate the potentially harmful effects of illicit drug use: supply reduction technologies; demand reduction technologies; and harm reduction technologies. In the following section I discuss these harm minimisation technologies in more detail and locate these within a conceptual framework of governmentality.

2.11.1 Supply Reduction Technologies

Supply reduction seeks to limit the availability of illicit drugs in the community and adopts a range of technologies to achieve this end. Customs officials and law enforcement experts play a central role in this area, and a variety of other experts including social scientists also contribute to this enterprise. These experts seek to prevent the importation of illicit drugs into the country as well as limit their distribution to consumers in the community. In order to realise this a number of governmental rationalities and technologies are brought into play. Expert bodies have been established that seek to identify importation and distribution networks in order to calculate where policing efforts should be best directed. This requires the development of a range of surveillance technologies that seek to identify major entry points, such as seaports and airports, as well as domestic distribution networks, in order to better target resources aimed at reducing the availability of illicit drugs. Further, it requires the development of partnerships with international bodies such as the International Narcotics Control Board, recognising that the drug trade extends beyond the borders of sovereign states. It also relies on the development of surveillance technologies that aim to make the amount and type of illicit drugs in the community calculable, thus seeking to enable the effectiveness of supply reduction technologies to be evaluated. These surveillance technologies also enable estimates of the economic value of the trade in illicit commodities to be made.

The surveillance technologies employed in supply reduction efforts include the use of x-ray machines and sniffer dogs to detect illicit drugs being imported through the various entry points. Also, in recent times across many cities in Australia police sniffer dogs have been increasingly employed at entertainment venues where they are

used to detect patrons in possession of illicit drugs. Surveillance technologies also include the employment of a range of instruments to monitor the use of illicit drugs in the community. One example of this is the Illicit Drug Reporting System (IDRS) that collects data from people who use illicit drugs, law enforcement personnel and service providers on an annual basis (Breen et al. 2004). This is aimed at enabling the early identification of changing patterns of drug use as they emerge and the subsequent refinement of strategies to respond to such changes. More recently in Australia we have seen the introduction of a government initiative, somewhat ironically named 'Pseudowatch', that seeks to limit diversion of common pharmaceuticals that can be used as precursors in the manufacture of various amphetamine type drugs. This program involves using pharmacists to monitor the sale of such pharmaceuticals, illustrating the rhizomic nature of the surveillance networks dispersed throughout the social body. Another such surveillance technology is the Health Insurance Commission (HIC) that monitors the prescribing of various pharmaceuticals. This enables the prescribing practices of medical practitioners, and consumption patterns of consumers, to be subjected to governmental scrutiny. As discussed above, surveillance technologies are a defining feature of neoliberal governmentality approaches to rule and supply reduction strategies fit within a governmentality schema.

2.11.2 Demand Reduction Technologies

Demand reduction is the second key component of Australia's harm minimisation approach to illicit drugs. Demand reduction aims to reduce the uptake of drug use and educate individuals and the general community about the risks of substance use. In terms of a governmentality framework this component of harm minimisation is based on the development of 'technologies of the self', and the neoliberal notion of the responsibilised, enterprising, prudential subject who will make informed decisions about their patterns of consumption. Demand reduction also relies on a relationship with supply reduction strategies discussed above whereby law enforcement technologies are seen as serving as a deterrent to the use of illicit drugs. This point is where the application of economic principles enters the governmentality of drug

control as supply reduction strategies are also aimed at inflating the price of illicit drugs thereby seeking to reduce demand. The success of this approach is, however, also questionable and research suggests it may actually increase the harms associated with illicit drug use (Bluthenthal et al. 2005; Dixon and Coffin 1999; Kerr et al. 2005; Weatherburn et al. 2002; Weatherburn and Lind 1997; Wood and Kerr 2005). Demand reduction also works in conjunction with supply reduction in the sense that it seeks to act as a deterrent to drug use as the prudential neoliberal subject is expected to calculate that the risk of being caught and punished outweighs the desire to use drugs (Moore 2004a).

Demand reduction technologies include drug education in schools, often using negative images of the harmful effects of drug use in an attempt to discourage young people from taking up illicit drug use in the first place. O'Malley (1999a) reviews some of the resources and policy documents relating to drug education in schools and treatment sites to support his argument that government seeks to produce 'responsible choice-making users' in order to make them governable. He posits that these resources seek to provide information to assist individuals to develop the necessary 'technologies of the self' and make informed decisions relating to substance use. Such enabling strategies seek to 'responsibilise' users, fostering a sense of autonomy and enterprise again aimed at rendering individuals as more governable (1999a:201-204). Another demand reduction technology is the increasing use of diversion programs whereby people caught using illicit drugs are directed to drug treatment services, rather than into the criminal justice system, where they are provided with information about the harmful effects of drug use by state sanctioned 'expert' diversion workers. This is another salient example of demand reduction strategies working collaboratively with supply reduction and, from a governmentality perspective, further illustrates the surveillance and disciplinary networks situated throughout the social body.

Demand reduction also relies on communication strategies as a technology for achieving its aims. Government agencies deploy a range of experts to develop communication strategies, including mass media campaigns as well as more targeted

campaigns aimed at specific audiences, which seek to reduce the demand for illicit drugs and associated harms for those that do use them. The discussion above about the responsibilising language contained in a range of resources by Fraser (2004) and O'Malley (1999a) are examples of such a technology. Again this approach relies on the governmentality notion of 'technologies of the self' whereby prudential individuals are considered more likely to make healthier lifestyle choices if the negative effects of illicit drug use are presented to them.

In relation to dependent drug use a similar view of the drug user as a rational choosing actor is deployed in seeking to form subjective individuals, albeit with more intrusive forms of governance (O'Malley 1999a). Pharmacotherapy technologies such as methadone maintenance are said to have as their main objective 'the governance of *risk generated by drug dependency'* (O'Malley 1999a:204 emphasis in original). The resources provided to individuals who enrol in methadone programs outline a number of benefits for consumers to support them in making 'informed choices' about their treatment. This aims to overcome the notion of coercion associated with compulsory treatment programs and seeks to further extend the governance of drug users by helping them develop the 'technologies of the self' deemed necessary to reduce risk, or what O'Malley describes as 'governing through choice' (1999a:205). This subjectivity of the dependent drug user, and the technologies deployed to reduce the perceived risks to the wider social body also relates to the third component of harm minimisation technologies, that of harm reduction.

2.11.3 Harm Reduction Technologies

Harm reduction technologies recognise the limited effectiveness of supply and demand reduction strategies, acknowledging that some people will continue to use drugs, and harm reduction is a technology that attempts to manage the risks associated with this. O'Malley (1999a) identifies this as an actuarial approach, another defining feature of governmentality. Moore (2004a) argues that harm reduction represents a new form of governmentality 'involving a shift from individuals subjects at-risk, and in need of intervention, to the expert surveillance and regulation of populations on the

basis of the collation of a range of abstract factors deemed liable to produce risk in general' (2004a:1548). Bunton contends that 'harm-reduction strategies did not displace other drugs strategies but supplemented them, effecting newer forms of governance' (Bunton 2001:227).

Aspects of harm reduction that can be analysed within a governmentality framework are the establishment of outlets for sterile injecting equipment and drug injecting rooms. Typically these services require clients to provide information such as age, gender and drugs being used, hence they can be seen as a further example of the use of surveillance technologies (Zajdow 2004:75) that, as discussed above, are a defining feature of a governmentality approach to rule. These services are governed and staffed by an assemblage of experts, such as doctors, nurses and social workers and, in some instances at least, people who use drugs in the role of 'peer educators'. Again this is an exemplar of the use of expert knowledge that demonstrates the utility of a governmentality framework of analysis for understanding contemporary approaches to illicit substance use.

Pharmacotherapy programs such as methadone are another governmental technology that seeks to mitigate the risks associated with illicit drug use. The use of pharmacotherapy technologies requires drug dependent individuals to maintain regular contact with a range of state sanctioned authorities, or 'experts', who collect an array of data relating to program participants, facilitating surveillance of this 'at risk' group (Zajdow 2004). Such pharmacotherapy programs have as their objective the modification of the drug consumption of these individuals. As such they can be considered another example of the 'conduct of conduct' whereby governments intervene to support individuals to adopt appropriate 'technologies of the self' that seek to produce a more prudential subject capable of adopting health protecting behaviours, such as a reduction in harmful drug use. This supports my argument that a governmentality framework is useful for analysing efforts to control illicit drugs and illicit drugs users 'at a distance' under neoliberal regimes.

With polydrug use, that is the use of more than one type of drug, a new set of problems emerges in terms of governing drug users. Actuarial approaches to drug use seek to establish levels of safe usage based on expert opinion. However, this is more difficult when a person uses more than one type of drug. O'Malley (1999a) argues that this unpredictability translates into a form of 'ungovernability' as there is no way of determining what the effects of polydrug use will be for individual users. However, I consider that the uncertainty of drug purity and strength that results from their proscribed status means that all illicit drug use, whether of one or more types of drug, contributes to a type of 'ungovernability'. O'Malley acknowledges this to some extent by identifying prohibition and law enforcement as risk factors in their own right as they contribute to an increase in 'black markets, drug adulteration and disrespect for the law' (1999a:200).

In this section I have argued that harm minimisation can be viewed as a governmentality approach to managing the issue of illicit drug use consistent with neoliberal principles of rational approaches to rule. Harm minimisation adopts risk management, or actuarial, approaches that are a defining feature of governmentality. However, given that the harms associated with illicit drug use continue, it begs the question of how such an approach can be considered rational? In the final section of this chapter I discuss what I consider to be a limitation of a governmentality framework for understanding the continued prohibition of certain substances and the persistence of contemporary approaches to substance use in Australia and propose an augmentation of this theoretical framework.

2.12 Augmenting a Governmentality Framework - The Political Economy of Scapegoating

In this chapter I have argued that, for the most part, contemporary approaches to illicit drugs can be understood within a governmentality theoretical framework. However, I consider that in order to better understand how this approach has evolved, and the reasons a pathologising-prohibitionist paradigm has continued to be the dominant

discourse in relation to substance use, in spite of a growing body of evidence that it is a failed approach, a broader perspective is needed.

An argument I find compelling, and consider needs to be integrated with a governmentality framework for better understanding the persistence of contemporary prohibitionist approaches to illicit drugs is posed by Samuel Friedman (1998). Friedman posits the notion of the 'political economy of drug user scapegoating' as a useful theoretical concept. He argues that rather than viewing the seeming failure of the prohibitionist approach, and the costs and harms associated with this, as a failed policy it should, instead, be viewed as a strategic and calculated approach to rule. He suggests that 'policies that maintain or increase drug-related harm may be less an "error" than a rational way to defend the interests of the powerful' (Friedman 1998:15). Friedman argues that people who use illicit drugs are 'extremely vulnerable to scapegoating, and such scapegoating can divide workers and neighbourhoods in ways that weaken opposition to socioeconomic changes and policies and strengthen punitive and individualistic ideologies' (1998:15). By diverting attention from the flaws of neoliberalism, and pursuing what he describes as 'harm-maximization' policies that 'encourage hate and fear towards drug users' (1998:17), somewhat akin to Cohen's 'folk devils and moral panics' (2002), their 'capacity to be involved in decision-making and interventions around compliance issues and around therapy development is simply not discussed' (Friedman 1998:18). Becker's (1963) conceptualisation of the creation of 'outsiders' is also of salience in relation to understanding this phenomenon, as is Crawford's (1977) concept of 'victim blaming'. I consider these to be key factors that undermine the potential for partnerships with people who use illicit drugs to operate effectively.

Friedman contends that the crisis faced by neoliberalism in an economic climate of declining profit margins, increased global competition, increasing income inequality, and reduced public expenditure on health and welfare for the poorest, most marginalised groups in society, has led corporate and political elites to 'use 'divide and rule' politics in which 'scapegoating' divides and distracts potential opposition' (1998:23) to neoliberal styles of government. Friedman's paper was written a decade

before the 'Global Financial Crisis', as it has become known, and remains pertinent today. This political economy perspective has, in my view, not been adequately addressed in the governmentality literature. Foucault himself argued that

> the transition that takes place in the eighteenth century from an art of government to a political science, from a regime dominated by structures of sovereignty to one ruled by techniques of government, turns on the theme of population, hence also on the birth of political economy (Foucault 1994a:217-18).

Given Foucault's original conception of 'the introduction of economy into political practice' (Foucault 1994a:207) as being an essential issue in the establishment of the 'art of government' for maximising the resource of population, I consider this perspective critical for understanding the prohibition of certain drugs in contemporary neoliberal societies and the continued marginalisation of people who use illicit drugs in policy development and service delivery planning processes. This perspective is particularly pertinent for understanding the limited success of partnerships involving people who use illicit drugs that I discuss in more detail in the following chapter.

In this chapter I argued that a theoretical framework of governmentality provides a sophisticated understanding of contemporary neoliberal approaches to illicit substance use and outlined my reasons for choosing this framework of analysis over possible alternative approaches. I provided a brief genealogy of liberalism and neoliberalism as portrayed by a number of key governmentality theorists and also described its 'darker side', that of authoritarian or 'despotic' liberalism, arguing that this forms a key component of classical liberal political discourse. I described some of the inherent contradictions of neoliberalism and a prohibitionist-pathologising approach to certain drugs, arguing that they ignore key principles of liberal approaches to rule in contemporary consumer societies. These contradictions have been significant factors in impeding the realisation of an 'ideal governmentality' approach to drug use, as I proposed in Chapter One, and have contributed to the continued failure of developing effective strategies and processes to involve people who use illicit drugs in policy development and service delivery planning.

I also provided a definition of two key concepts of governmentality, 'governing at a distance' and 'technologies of the self' and argued they can be effective concepts for understanding the practice of partnerships involving users. I also described how the concept of harm minimisation could be considered a component of a governmentality approach to rule. In the final section of this chapter I outlined what I consider a useful augmentation to a governmentality framework, that of the political economy of drug user scapegoating, for understanding how the concept of partnerships has met with limited success, as I discuss in depth in later chapters. The utility of these theoretical perspectives for explaining the practice of these partnerships is tested through the analysis of a range of policy documents, as well as through in-depth interviews with people who work in these 'partnerships'.

In the next chapter I continue to develop my argument about the utility of a governmentality framework for understanding partnerships by focusing on some key concepts of neoliberal approaches to the issue of substance use and the governance of substance users. These concepts include 'medicalisation', 'evidence-based policy' and what I describe as 'the pharmaceutical panopticon'. I conclude the chapter with further suggestions for augmenting a governmentality framework.

Chapter 3 - Governmentality and Partnerships with Drug Users

3.1 Introduction

In this chapter I continue to develop my argument that the theoretical framework of governmentality provides a useful analytical tool for understanding of contemporary neoliberal responses to illicit drug use, this time focusing on the notion of 'partnerships' involving illicit drug users. I begin my discussion by describing the practice of partnerships involving people who use illicit drugs and argue that this can be understood within a governmentality framework. I then provide an overview of Foucault's critique of health and the concept of biopower. I follow this with an argument about several defining features of contemporary neoliberal responses to illicit substance use that fit within a governmentality theoretical framework and can contribute to a better understanding of such partnerships. I also develop a concept that I describe as 'the pharmaceutical panopticon' and argue this fits within a governmentality framework and contributes to understanding the limited success of partnerships involving people who use illicit drugs. Finally, I again contend that other theoretical perspectives such as the 'utility of identifying a suitable enemy' (Room 1999) – a concept originally developed by Nils Christie (1986) - along with the 'political economy of drug user scapegoating' (Friedman 1998) discussed in the previous chapter, need to be considered in conjunction with a governmentality framework to better understand why the neoliberal enterprise of partnerships involving people who use illicit drugs has had limited success.

3.2 Partnerships Involving People Who Use Illicit Drugs

Policy development and service delivery planning processes across a range of chronic disease areas in Australia purport to be underpinned by a reliance on partnerships intended to produce better health outcomes and reduce the burden of disease on the wider community. In the drug policy sector this consists of partnerships between various levels of government, health and law enforcement agencies, non-government organisations and 'affected communities' (ANCARD 1999; Feachem 1995; Single

and Rohl 1997:8). The whole notion of partnerships in the drug sector is, however, an arena of contestation and often not clearly understood, even by those considered partners. This is evident in a number of evaluations of policies and strategies that seek to reduce harms related to drug use (ANCARD 1999; Feachem 1995; Single and Rohl 1997). In regard to such partnerships it is worthwhile recalling Gordon's (1991) point that Foucault believed there was 'a way for the governed to work with government, without any assumption of compliance or complicity, on actual and common problems' (Gordon 1991:48).

The concept of partnerships has become ubiquitous in contemporary social policy under neoliberal regimes and can be situated within a governmentality approach to rule under the banner of the 'New Public Health' which I discuss in more detail below (Petersen 1997; Petersen and Lupton 1996). However, Atkinson (1999) argues that partnerships are a discursive construct subject to the exercise of power and merely serve to reinforce the subjugation of disenfranchised groups. Hastings (1999) and Lister (1999) argue that the issue of power in partnerships has been largely ignored by researchers with the main focus having been on the decision-making structures and functional processes of partnerships. Foucault argued that 'the exercise of power is not simply a relationship between "partners", individual or collective; it is a way in which some act on others … it is not by nature the manifestation of a consensus' (1994b:340).

The concept of partnerships adopted under the National Drug Strategy (NDS) represented a shift towards a 'consensus model of policy making using a policy community approach' (Fitzgerald 2004:51). However, the 'differing policy positions and objectives between community organisations and governments on various levels have, on occasion, led to difficulties in the practice of partnerships' (ANCARD 1999:ix). This is consistent with Foucault's view on power that

> at the very heart of the power relationship, and constantly provoking it, are the recalcitrance of the will and the intransigence of freedom. Rather than speaking of an essential antagonism, it would be better to speak of

> an "agonism" – of a relationship that is at the same time mutual incitement and struggle; less of a face-to-face confrontation that paralyzes both sides than a permanent provocation (Foucault 1994b:342).

In the Australian 'drug policy community' the notion of partnerships remains an area of significant contestation and struggle (Fitzgerald and Sewards 2002) – somewhat akin to the 'agonism' alluded to in the passage from Foucault quoted above. This is compounded by the neoliberal purchaser-provider funding model which operates between government and service providers and the 'often inequitable power-relations between government and other stakeholders' (Fitzgerald 2004:58) that result from such a model.

Non-government organisations also felt their involvement in decision making and policy formulation had been reduced over time with the introduction of reforms to public health funding (ANCARD 1999:132). This had led to 'a growing sense in the community sector that they are increasingly excluded from new and emerging partnerships in the public health sector' (ANCARD 1999:135) which was felt to have harmed these partnerships. Adding to this complexity is the fact that numerous actors outside of the 'partnership' play an active role in influencing government approaches to drugs: these actors include the media, conservative politicians and the anti-drug lobby (Gunaratnam 2005:2). As discussed earlier the concept of governmentality acknowledges 'the complexities, subtleties and micro-negotiations of relations of power' (Petersen 1997:203) and this is critical for understanding the practice of partnerships involving people who use illicit drugs.

The conflict between the rhetoric of policy documents and practice of partnerships discussed above has created a level of distrust and tension within the Australian drug policy community, more so with the increasing influence of abstinence-based advocates, including several members of the ANCD, in the policy development process (Fitzgerald 2004). Prior to the formation of the ANCD this tension was identified in the evaluation of the National Drug Strategy 1993-1997 titled *Mapping The Future* (Single and Rohl 1997) when discussing the constraints faced by non-

government organisations in working in partnerships. One of the respondents to the evaluation claimed 'giving comment can have dramatic consequences down the track' (Single and Rohl 1997:69), where speaking out against government could negatively influence funding decisions. A subsequent study found that the Howard Government increasingly used the powerful tool of 'withdrawal or threat of withdrawal of government funding' (Hamilton & Maddison 2007a:3) to 'silence dissent' among non-government organisations. Such tensions in partnerships occur in a variety of health and welfare sectors across different countries. Jacobs (1999) noted similar concerns existed within partnerships in the United Kingdom where partners feared 'public opposition [to government policy] would put in jeopardy future bids for housing and regeneration projects' (Jacobs 1999:109). In Australia a proposal by the Federal Treasurer to 'disqualify a charity that engages in advocacy that is other than ancillary or incidental' (Maddison et al. 2004:vii) is further evidence of government attempts to undermine the role of non-government organisations in partnerships and 'silence dissent' (Hamilton & Maddison 2007b; Maddison et al. 2004). Again this resonates with Foucault's view of power and agonism and that 'the exercise of power is not simply a relationship between "partners" … it is a way in which some act on others' (1994b:340). The issue of 'silencing dissent' is discussed in more detail in Chapter Seven where I identify this as one of the key themes arising in interviews with members of partnerships in the drug policy sector.

As with the policy development process the concept of partnerships in health service delivery planning has also become an increasingly prominent feature of neoliberal governmentality regimes since the 1980s as part of the 'New Public Health' project (Petersen and Lupton 1996). The Australian Government claims

> involving the community in decision making about their own health, as well as the planning and management of health services is integral to effective health promotion and illness prevention (Better Health Outcomes for Australians, 1994, Commonwealth Department of Human Services and Health *in* AIVL 2008:5).

Hinton (2010) defines drug user involvement in partnerships as

> the active participation of people who, because they have used services or are potential service users, can bring their knowledge and experience to contribute to the design, planning, delivery and evaluation of services (2010:13).

She notes that a key difference between drug treatment services in the UK and Australia is that in the UK there is a statutory requirement that consumers are to be involved in the planning and development of services. Consumers are also resourced to facilitate their involvement (Hinton 2010:9, 20).

The concept of partnerships provides a sense of legitimacy in service delivery planning by conveying a sense of inclusion and representation in the process (Bryant et al. 2008a, b), while also conveying a sense of obligation on consumers that they play an active role in order to attain better health outcomes. This is part of a wider neoliberal governmentality project of creating 'active', responsible citizens (Bunton 2001; Contandriopoulos 2004:322; Ilcan and Basok 2004:130; Petersen and Lupton 1996:146; Rose 1999) where the 'citizen as consumer is to become an active agent in the regulation of professional expertise' (Rose 1999:166). While this concept is ostensibly aimed at improving health outcomes it is also intended to reduce the increasing costs of health care to the state (Scott and Thurston 2004:483). This again reflects Foucault's view that essential to the establishment of an 'art of government' as a means of managing the resource of population was 'the introduction of economy into political practice' (Foucault 1994a:207). Fraser and Valentine (2008) argue that the involvement of people who use illicit drugs reflects the 'New Public Health' project of involving consumers in policy and service delivery planning processes, recognising that they possess 'specific expertise as well as experiential perspectives' (Fraser and Valentine 2008:127) that could improve these processes. This is consistent with Foucault's notion of the 'specific intellectual' who 'begins to intervene in contemporary political struggles in the name of a "local" scientific truth' (Foucault 1994c:129).

As previously discussed, the concept of involving people who use illicit drugs in partnerships in Australia had its origins in the context of government responses to

HIV/AIDS among people who inject drugs in the 1980's (Hinton 2010:76). It has been argued, however, that had this virus not primarily been among gay men in Australia, who had access to a range of resources, including political leverage, the 'community response would have been greatly restricted' (Ballard 2005:10) and the promotion of partnerships with people who inject drugs, a community that was more heavily marginalised, may not have been as strong (Ballard 2005). The effectiveness of involving people who use illicit drugs in partnerships is an area in which little research has been conducted, although it has been argued that 'experience has shown that user groups have played a critical role in the partnership between government officials, affected communities, clinicians and researchers' (Wodak 2005:37). It has also been argued user groups played a significant role in the partnership approach to preventing the spread of HIV/AIDS among people who use illicit drugs (Friedman, S. 1998; Friedman et al. 1993; Treloar et al. 2006; Wodak 1993). The role user groups played in developing overdose prevention strategies, in partnership with police and ambulance services, is another example cited where partnerships have been effective (Wodak 2005). Additionally, partnerships with people who use illicit drugs are said to have been effective in the collaboration with research bodies looking at a variety of aspects of HIV/AIDS and HCV where user groups have been closely involved with researchers in the design and conduct of a range of research projects (ANCARD 1999:72). One recent example of this is a joint research project between the Australian Injecting and Illicit Drug Users League (AIVL) and the National Centre in HIV Social Research (NCHSR) which aimed to develop definitions and models for drug user participation in service development (AIVL 2008). A report on the second stage of this project is currently awaiting approval for release by the Federal Government (Madden 2010). Again this is consistent with Foucault's view that working with government does not, in itself, imply subjugation (Gordon 1991:48), rather it is a pragmatic approach aimed at producing better health outcomes for people who use illicit drugs.

However, it has been found that involving people who use illicit drugs in partnerships has proven to be problematic

> the problems stem from the illicit nature of injecting drug use and inadequate resourcing for community representation. Unlike members of the gay community, people who inject drugs do not share social spaces and political aspirations to any notable extent. The situation is exacerbated by the splintering effect that enforcement of drug policy has on groups of people who inject drugs. These factors, coupled with inadequate funding, make it difficult to secure the full participation of people who inject drugs in the partnership (ANCARD 1999:134).

Similarly, Fraser and Valentine, who adopt a Foucauldian framework to analyse how methadone consumers are 'made up' in neoliberal societies, argue that the 'metaphorical figuration of regular drug use as a kind of surrender to (and of) the powers of speech … [means] pharmacotherapy clients are often excluded as stakeholders from policy development around treatment provision' (2008:45). The involvement of people who use illicit drugs in policy development is further complicated by the fact that they are 'in the unique, although unenviable, position of occupying the locus of attention of several modes of regulation; legal, moral and medical' (Smart 1984:31).

As with their role in partnerships the effectiveness of drug user organisations in reducing drug related harms among their peers is an area in which a lacuna of evidence exists, particularly in Australia subsequent to the successful role they played in curbing the spread of HIV/AIDS among injectors. A corpus of articles were published in the early to mid-1990's that attested to this role (e.g. Crofts and Herkt 1993; Friedman et al. 1993; Herkt 1993; Trautman 1995; Wodak 1993), however, little published research exists from recent years. This is, in large part, due to issues of resourcing, as I discuss in more detail in chapters five and six in which I discuss the main themes raised during interviews with a range of 'partners'. In the absence of such evidence, funding to AIVL and a number of State peer-based organisations has continued on an *ad hoc* basis primarily for such activities as HIV/AIDS, HCV and overdose prevention programs over the last decade. Reporting by these organisations on the use of this funding has largely been based on outputs, rather than outcomes that

would demonstrate evidence of effectiveness, so it is difficult to evaluate how successful this approach has been (Madden 2010). Later in this chapter I discuss the notion of evidence-based policy and argue that it is often subjected to a range of political factors rather than based on rational scientific evidence as would be expected under an 'ideal governmentality' approach. In the following section I provide an overview of Foucault's contribution to the sociology of health and follow this with discussion of some other key theoretical concepts including 'medicalisation' and the 'New Public Health'.

3.2 Foucault and Health

In this section I provide an overview of Foucault's conceptualisation of the emergence of the medical profession as a powerful and privileged sector as a background for concepts I discuss in later sections. In his essay *'The Politics of Health in the Eighteenth Century'* Foucault (1984a) describes the emergence in Western Europe of organised health systems, both private and 'socialised', and what he calls 'noso-politics' - nosology being the knowledge and classification of diseases. Foucault argued these new structures came about in order to ensure populations were better able to meet the demands of the 'apparatus of production' (Foucault 1984a:278) and reduce the burden of illness on the wider social body. According to Foucault

> different power apparatuses are called upon to take charge of "bodies", not simply so as to extract blood service from them or levy dues, but to help and, if necessary, constrain them to ensure their good health. The imperative of health: at once a duty of each and the objective of all (Foucault 1984a:277).

Foucault argued this arose as the result of a population increase that necessitated the coordination and integration of this resource and the development of a 'technology of population'. This technology included the emergence of a range of surveillance mechanisms whereby the

> biological traits of a population became relevant factors for economic management, and it becomes necessary to organise around them an

> apparatus which will ensure not only their subjection but the constant increase of their utility (Foucault 1984a:279).

This technology of population is central to Foucault's concept of 'biopower' – or power over life. One component 'centred on the body as a machine: its disciplining, the optimization of it capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls' (Foucault 1998:139). The second component of this 'technology of population'

> focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and *regulatory controls: a biopolitics of the population* (Foucault 1998:139 emphasis in original).

Evidence of this technology of population can be seen in contemporary health policy and the emphasis placed on utilising information technology, such as the Medicare Smartcard, that further extends the surveillance capacity of the state. These surveillance technologies enable the collection of a range of data at both an individual and population level, much of which is used as 'evidence' to inform policy development processes.

Foucault argued that central to 'noso-politics' was the positioning of medicine as an apparatus of social control and the emergence of a 'medico-administrative knowledge' and a set of 'politico-medical prescriptions' relating not only to disease but also to behaviours. Medical bodies were granted a number of administrative responsibilities and, in some cases, authoritarian measures to support the functions of the state. This bestowed on the medical profession a politically privileged position that in the nineteenth century extended to economic and social privileges (Foucault 1984a:283-284).

In *'The Politics of Health'* Foucault also traces the changing structure of the health system. He describes the shift away from hospitalisation of the ill to a more economically efficient means of caring for the sick in the community. This required the development of 'a medical corps dispersed throughout the social body' (Foucault 1984a:284) and able to provide a level of health care which reduced the economic burden on the state. In order to implement this policy a number of measures were taken to facilitate a wide distribution of doctors in both rural and urban locales. This policy also enabled the extension of surveillance technologies into ever increasing areas of life. Similar policies exist today. A range of administrative and support structures, as well as financial incentives, are provided to General Practitioners by the Federal Government to locate to rural and outer urban areas. In addition the Federal Government offers incentives for providing a range of 'allied health services' and 'health care plans' aimed at further easing the burden on the hospital system. More recently there has been a move to employ Nurse Practitioners to enhance the presence of health professionals in community settings and ease the burden on the General Practice workforce. This further facilitates the expansion of capillaries of surveillance networks that are a recurring theme in Foucault's theories on power/knowledge.

Much of Foucault's key works were written in the period prior to a number of significant changes in most Western health care systems. These transformations have been consistent with neoliberal principles and include economic restructuring of health systems in line with the mechanisms of the market and the concept of consumer choice and a reduction in state intervention (Osborne 1997). In addition, the concept of risk management has become a key factor in shaping health policy (Bunton 1997; Turner 1997). However, while Foucault's work continues to provide a number of valuable insights into the analysis of contemporary health care systems (Bunton 1997), in order to better appreciate the relevance of his work to contemporary health care policy it is necessary to look at others who have adopted Foucauldian approaches in their analyses of various aspects of health in more recent times. This is discussed in more detail in the following section.

3.3 The Medicalisation Critique

In this section I argue that 'medicalisation', particularly in relation to the treatment of illicit drug users with pharmacotherapies such as methadone, provides a useful framework for understanding the increasing power of the medical profession to define deviance as authorised agents of the state. This, in turn, supports the state's surveillance technologies of a 'deviant' element of the population consistent with a governmentality approach to rule by utilising experts 'at a distance' from the state. Medicalisation has been a growing field of interest for sociological enquiry since the 1960s and has been taken up by a number of medical sociologists with the aim of challenging the increasing power of the medical profession. The basic tenet of this critique has been that the medical profession has increasingly gained power and influence, in spite of its lack of effectiveness in treating a wide range of conditions, as well as creating a range of undesirable side effects and harms (Lupton 1997). Petersen (2003) argues that it is critical that when analysing contemporary health systems that researchers

> need to rethink the concepts of power and politics if they are to formulate an effective response to the unjust and dehumanising aspects of neoliberal policies and practices that have come to dominate many contemporary health care systems and to create greater ethical awareness in health care (Petersen 2003:193).

The process of medicalisation can be considered a function of the administered society in which professional groups define deviance on behalf of the administrative state (Turner 1987). This theoretical framework views the medical profession and associated 'psy' disciplines (Rose 1996b) as a product of the administrative state, entrusted with the role of policing the behaviour of individuals and using their state sanctioned professional status to enforce compliance with societal norms. This provides the means of maintaining surveillance over the activities of citizens and, where necessary, acting on behalf of the state as institutions of normative coercion (Turner 1987). The medical profession is able to exercise this authority because their coercive nature is not always obvious and they are 'readily accepted as legitimate and

normative at the everyday level' (Turner 1997:xiv), an exemplar of 'governing at a distance' as previously discussed.

The application of epidemiology and utilising the notion of risk to construct social problems and support the role of the biomedical sector in developing technologies as 'remedies' is also central to the medicalisation critique. While the medical profession argues epidemiology provides a sound scientific body of evidence for identifying risk and developing biomedical technological solutions, critics of medicalisation argue that positivist epidemiology constructs risk in such a way as to foster individualism that leads to a 'blame the victim' mentality and obscures the social and political causes underlying these conditions (Crawford 1977; Miller 2001). Furthermore, the indicators used and methodology employed to support these 'truths' are open to question (Lupton 1995:67-8, 92; Rowe 2004b:117; Zajdow 2004:76) and, in relation to illicit drug use, are described by Miller as little more than 'a patchwork of guesstimates' (Miller 2001:176).

Foucault's genealogical methodology historically locates the rise of medical power/knowledge and the historical construction of the body making it particularly useful as a starting point for looking at medicalisation and social control, particularly in relation to substance use (Bergschmidt 2004; Samuelsen and Steffen 2004; Turner 1997). The issue of medicalisation and substance use is discussed in more detail in the following section.

3.3.1 Medicalisation and Substance Use

In this section I extend the argument that the process of defining social problems and deviance has increasingly been annexed by the medical profession and the various 'psy' disciplines (Rose 1996b), positioning these professions in positions of power whereby they take on an increasing role as agents of social control (e.g. Bourgois 2000; Freund and McGuire 1991; Friedson 1970; Lupton 1997; Petersen 1994; Szasz 1974; Turner 1987; White 2002). This has led to a transformation of what are essentially political and moral evaluations of 'proper' behaviour into scientific claims that are beyond dispute (White 2002:52). Further, the medical profession is constantly

manoeuvring to enhance its position in society by seeking to become the principal arbiter of defining illness and prescribing treatments, the result being a subordination of the opinions and knowledge of lay people and a consolidation of the status of the medical profession. In such a discursive environment, the role of people who use illicit drugs is generally one of subjugated knowledge and disenfranchisement as their use of these substances has become the subject of medical and legal debate.

Within neoliberal societies social problems are constructed in a manner that enables solutions to them to be turned into mechanisms for profit by the medical-industrial complex (White 1991, 2002) and leads to 'a focus on individuals in already subordinated groups' (White 2002:65). Defining deviance is a social process involving a range of factors such as power and the medical profession and 'psy' disciplines (Rose 1996b) have increasingly benefited from being authorised to perform this role. Such a process has been described as 'business friendly social policy' (Shin 2000). Following Becker (1963), Freund and McGuire (1991) see those in positions of power in society as having influence in defining social norms and labelling deviance, as well as having control of the mechanisms by which these norms are enforced. Medicalisation critiques resonate with this line of thinking and argue that the power of the medical profession means that they support the state in the construction of deviance as a means of shoring up their elite position within society, thus ensuring they maintain a role in developing responses to deviance that supports their business interests. This materialist perspective has particular relevance to the methadone program as it operates in Tasmania, with its philosophy that *'service delivery by the private sector ensures that treatment is delivered in a resource efficient manner'* (DHHS 2000:8). A similar situation exists in NSW where, alongside a system of public clinics, a number of private drug treatment clinics exist and operate to profit from 'the management of human misery' (Rose 1993:284). However, the failure of the private sector in Tasmania to adequately provide pharmacotherapy services, in part due to insufficient incentives (Fraser and Valentine 2008), has seen the re-establishment of a public clinic to meet increasing demand, although only in the capital city of Hobart.

Parsons' model of the sick role has been criticised as inadequate as he regards the diagnosis and treatment of medical deviance as purely technical, neutral and unbiased (Freund and McGuire 1991:127). Freund and McGuire (1991) contend instead, that the definition of illness is socially constructed and that the responsibility for illness is often placed on the 'sick' person. Certain conditions, such as illicit substance use, are often viewed as individual weaknesses that are subjected to negative moral judgements and often treated punitively (Friedson 1970). In addition specific social and historical conditions often lead to the stigmatisation of certain conditions (Freund and McGuire 1991). What was once largely a matter of personal choice has now been classified as pathological and proscribed (Macintosh 2006; Manderson 1992, 1993). It has been argued that there has been a decline in the importance of religious definitions of deviance since the Enlightenment, as they often appear too 'non-rational'. Medical definitions on the other hand have gained greater credence, as they are considered more rational and scientific, again demonstrating the increasing acceptance of the medical profession as a legitimate arbiter of illness or deviance and, therefore, an agency of social control. However, the social control functions of 'therapeutic interventions' are not always hidden and often involve coercion (Freund and McGuire 1991). Recent proposals relating to compulsory treatment for 'drug offenders' support this argument and are a topic of debate among those working in the field, as well as among drug user advocacy groups (Wodak et al. 2004). This also reflects a resurgence in the influence of faith-based abstinence approaches in contemporary drug policy and a 'new morality' evident in the social policy arena (Hamilton, M. 1993:361; Macintosh 2006; McDonald et al. 1994).

Furthermore the medical profession have had their authority to define social problems legitimated through their claims to be able to provide technological solutions to social problems (McArthur 1999:3). Methadone, a medical technology, is an example of how the state seeks to engage the medical profession in acting as agents of social control and, by bringing addicts into regular contact with authorities, provides improved surveillance technologies of individuals on pharmacotherapy programs (Zajdow 2004:75). This serves to expand 'the areas of influence of the medical

profession which has a vested interest in defining and constructing social problems' (McArthur 1999:3) and further facilitates the capacity to 'govern at a distance' through an assemblage of 'experts' dispersed throughout the social body, as discussed in the previous chapter.

The medicalisation of social issues such as illicit substance use, particularly by the discipline of psychiatry, is another example where 'experts' have had a significant influence on defining 'appropriate' normative behaviour. The categories used to classify illness do not always have a biological basis but reflect the values of medical professionals and the state of which they are agents of control (Szasz 1974). Szasz (1974) posits that substance use has been appropriated by the science of pharmacology in an effort to medicalise this phenomena and subject it to social control through a discourse of prohibition and persecution, while failing to take into account the broader social, cultural and 'ceremonial' aspects of drug use, or indeed the concept of self-medication. Adopting an 'archaeological' approach similar to Foucault's in terms of tracing the origins of various 'scientific' explanations for deviance, he compares the *pharmakoi*, or scapegoat, of ancient Greece - noting the irony of the term that later came to mean medicine or drug - to that applied to certain substances and certain persons in discourses about drug use in modern times. Szasz (1974) argues that, just as in the ancient world where the roles of priest and physician were not separated, in the modern world church, medicine, and state continue to collaborate in maintaining social order by regulating personal conduct. The increasing influence of faith-based abstinence advocates in the drug policy arena in recent years, as I discuss below, supports this view.

In regard to the way medicalisation and conservative moral views have impacted on the issue of substance use Szasz argues that

> psychiatric interventions with persons stigmatized as "drug abusers" and "drug addicts" are here represented as "help" which the "patients" want in order to stop taking illegal drugs , where it is actually imposed upon them by law by those who want them to stop this habit; and the policies of psychiatrically harassing persons who take illegal drugs, and of using

> tax monies to supply them with legal drugs (such as methadone), are accepted unquestionably and uncritically as medically indicated and morally justified (1974:12).

The argument of the biomedical sector claiming to be able to provide technological solutions to social problems has also been taken up by Bourgois (2000). Adopting a Foucauldian framework, Bourgois contends that 'methadone is especially appealing to treatment scientists because the biomedical world is dedicated to solving complex social ills by developing laboratory-based, high-tech potions that promise quick fixes and easily replicable efficient outcomes' (2000:173). He argues that methadone is a perfect technology for producing a 'passive self-deprecating obedience' among consumers and represents an attempt on the part of the state to inculcate moral discipline on those who 'reject sobriety and economic productivity' and that the 'addictive properties of methadone … make it too physically painful for them to misbehave' (Bourgois 2000:183). Bourgois contends that state and medical authorities have created a distinction between methadone and illicit opiates based on a discourse of 'moral categories concerned with controlling pleasure and productivity: legal versus illegal; medicine versus drug' (2000:167).

The resistance practices adopted by consumers who 'by strategically varying, supplementing, or destabilising the effects of their dose with poly-drug consumption, methadone addicts can augment the otherwise marginal or only ambiguously pleasurable effects of methadone' (Bourgois 2000:180) sit well within Foucault's view of power where 'resistance is an endemic fact in the world of power relations' (Gordon 1994:xx). Much the same resistance practices have been noted among Australian methadone consumers (Fraser and Valentine 2008; Lintzeris et al. 1999; Nielsen et al. 2008; Ritter and Natale 2005; Winstock and Lea 2010) as they seek to enhance what the medical profession, as legitimised agents of the state, have prescribed as an acceptable treatment modality. It is these resistance practices that have given rise to increased technologies of surveillance of people on pharmacotherapy programs, a concept I describe as 'the pharmaceutical panopticon' that I discuss later in this chapter.

Medicalisation has not, however, been universally condemned in relation to illicit substance use. Singer (2001) has described it as a possible "Third Way" approach with the potential to break the deadlock between 'drug warriors' and those calling for a more libertarian approach to the use of currently illicit substances. Singer highlights the division between these two camps by arguing that

> advocates of the present policy fear medicalization is a dangerous first step towards complete legalization of drugs proscribed by the state. On the other hand, others complain that medicalization merely replaces the prison bed with the hospital bed (2001:2).

Singer argues that opponents of drug prohibition see medicalisation as further reducing the autonomy of the individual and merely an extension of the 'therapeutic state' described by Szasz (1984) and a continuation of the pathologising of drug use. Singer is sympathetic to Szasz's perspective, however, but sees medicalisation as a possible strategy that can be deployed to end the 'war on drugs' by mobilising 'experts' who can utilise a 'new public health' discourse to bring an end to what he describes as 'oppressive and ineffective policies' (2001:6-8). Singer cites empirical evidence from the struggle to have certain drugs made legal by medical prescription in certain States in the USA to support his argument for mobilising a medicalisation approach in the 'war on drugs'. He argued that doctors and patients working together against the government represented a 'new public health' approach to the issue of currently proscribed substances (2001:9). Singer's use of this term differs, however, to the more conventional theoretical concept of the 'New Public Health'. I discuss this in more detail in the following section and argue that it can limit the effective involvement of people who use illicit drugs in partnerships by viewing their expertise as a form of 'subjugated knowledge' (Foucault 1997:7).

3.6 The 'New Public Health' and Substance Use

In this section I argue that the theoretical concept of the 'New Public Health' is a critical component of a governmentality approach to rule in neoliberal societies and provides a useful framework for understanding the concept of partnerships involving

people who use illicit drugs. The 'New Public Health' can be briefly summarised as a neoliberal social enterprise based on notions of risk management, surveillance, health promotion and self-care consistent with a governmentality approach to rule (Petersen and Lupton 1996).

The 'New Public Health' relies heavily on expert knowledge while also promoting the concept of building individual and community capacity as critical in developing effective responses to health issues (Petersen 1997; Petersen and Lupton 1996:67; Zajdow 2004). It is this notion of building community capacity through 'the participatory imperative' and 'active citizenship' (Petersen and Lupton 1996:147) that has seen the notional practice of 'health promoting partnerships' flourish in neoliberal societies. However, the reliance on expert knowledge that is a central tenet of the 'New Public Health' also serves to undermine the lay knowledge of consumers (Petersen and Lupton 1996:153; Zajdow 2004:75) and this is a critical factor in the limited success of engaging people who use illicit drugs in partnerships. The subjugated *savoirs* of illicit drug users, which I discuss in more detail below, serves to marginalise them due to their perceived poor lifestyle choices.

Petersen and Lupton argue that good health through the pursuit of healthy lifestyle choices

> is related to virtuous citizenship because of the benefits that extend from the individual to the social body. A healthy person is able to take part, to the best of his or her physical ability, in contributing to the nation's prosperity (1996:67).

On the other hand, should a person not make 'healthy lifestyle choices' then they risk incurring significant sanctions as seen in the USA where women have been charged with neglect and distribution of drugs to a minor for using drugs while pregnant (Chavkin 1990:484; Polanda et al. 1993). Similarly, former Prime Minister Howard proposed 'quarantining' of welfare payments for people convicted of 'hard' drug offences (Karvelas and Stapleton 1997). This is consistent with the concepts of 'authoritarian' or 'despotic' liberalism (Dean 2002; Hindess 2001; Valverde 1996)

discussed previously. It also resonates with Zajdow's argument that while the 'New Public Health' characterises individuals as autonomous actors consistent with neoliberal ideals, their choices and actions are only possible 'within circumscribed boundaries' (Zajdow 2004:75).

There is a growing body of evidence that suggests the emergence of neoliberalism has coincided with a 'duties discourse' in which the notion of individual rights is tied in with a concept of reciprocal duties (Petersen 2003:194; Petersen and Lupton 1996). Petersen argues that people

> who seek to operate outside predetermined lines of action risk being labelled irresponsible or as troublemakers and suffering financial penalty of some kind or being denied access to services or advice (2003:195).

This view is supported by a study into the financial burden borne by pharmacotherapy clients that found they were discriminated against by the Commonwealth Government in terms of existing Pharmaceutical Benefits Scheme (PBS) arrangements 'by failing to subsidise dispensing fees for those on programs' (Rowe 2009:1). Under the Howard Government a coercive approach to dealing with illicit drug use saw the introduction of a Bill to the Federal Parliament seeking to entrench in law the right to discriminate against people addicted to illicit drugs unless they were undergoing treatment. Supporters of the Bill argued that it would keep the work environment safe for others (Wodak et al. 2004). This attempt to legislate to allow discrimination against illicit drug users supports Petersen and Lupton's (1996) claim of a 'duties discourse' and is evidence of a 'new morality' in health policy (Hamilton 1993:361; Macintosh 2006). The significant number of faith-based organisations receiving government funding in Australia to provide drug treatment services also supports this perspective that moral positions play a significant role in policy development processes.

The idea that authoritarian measures need to be imposed on populations to ensure an adequate supply of 'work ready' labour to support neoliberal enterprises is a recurring theme among 'New Public Health' theorists and has particular relevance to the use of

illicit substances and notions of 'active citizenship' (Bunton 2001; Petersen 1997; Petersen and Lupton 1996). Evidence of the emphasis placed on having a docile, 'work ready', population able to contribute to the neoliberal 'apparatus of production' (Foucault 1984a:278), as posited in the 'New Public Health' framework can be found in an issue of the journal *Substance Use and Misuse* (2004, vol.39 13-14) in which the entire issue is dedicated to a series of articles which look at a range of employment and 'vocational rehabilitation' programs for people with substance use issues. Journal articles in this issue include such titles as *"Addressing Persistent and Intractable Employment Problems in Individuals with Histories of Drug Addiction"* and *"A New Work Placement Model for Unemployed Methadone Maintenance Patients"*. This highlights the fact that a significant amount of funding for research into addressing drug issues under the 'New Public Health' is dedicated to ensuring a continued supply of 'work ready' labour, consistent with a governmentality approach to rule where population is viewed as a resource. It also highlights the fact that 'functional' drug use and the notion of the pleasurable aspects of this practice as a possibility is ignored, as I have discussed above. Such authoritarian approaches enable the largely unquestioned surveillance of those considered outside the realms of acceptable normative standards of behaviour and forms part of what I describe below as a 'pharmaceutical panopticon'.

3.5 The Pharmaceutical Panopticon

In this section I argue that Foucault's theories of surveillance and use of Bentham's concept of the panopticon are of particular relevance to the case of pharmacotherapy maintenance programs, a key technology of government efforts to reduce drug related harms. I discuss how the biomedical sector has developed a range of technologies and regulations that enable the surveillance and disciplining of people deemed not capable of bearing the responsibilities of governing through autonomous freedom and, instead, are subjected to authoritarian forms of governance as discussed in Chapter Two (Dean 2002; Hindess 2001). I also argue that this serves to further undermine the involvement of people who use illicit drugs in partnerships.

White (2002) and Fraser and Valentine (2008) describe some of the mechanisms of surveillance, both of consumers and health service providers, relating to methadone programs that operate in Australia and are constantly evolving with technological change. Some of these surveillance mechanisms include, at a national level, the Health Insurance Commission (HIC) and the Pharmaceutical Benefit Scheme (PBS) that function in collaboration with the Department of Health and Ageing (DOHA). In Tasmania, at the State level, a range of data is held by the Department of Health and Human Services (DHHS) relating to consumers, prescribers and dispensers as well as data on the distribution of equipment primarily used for the injecting of methadone. This is consistent with a governmentality approach that relies on surveillance technologies and the use of expert knowledge in order to maximise the resource of population as discussed in Chapter Two.

The requirement in Tasmania, as in all Australian states, that methadone consumers present to their dispensing pharmacist for their regular dose, often on a daily basis, is a useful technology for the state to keep 'deviants' under regular surveillance (Fraser and Valentine 2008; Zajdow 2004). The rationale behind requiring that consumers present regularly for dosing, rather than being allowed to self-administer their medication, is that it aims to reduce the incidence of diversion to the illicit market. The surveillance data on methadone injecting, however, with Tasmania having the highest rates in the country, particularly among those who obtain it from the illicit market, suggests this has not been entirely successful (Breen et al. 2004).

Fraser and Valentine (2008) also discuss how methadone is used as a technology to shape responsible subjects fit for a neoliberal vision of citizenship consistent with a governmentality approach to rule. Built into the program in Tasmania, as in most other States, are incentives whereby consumers who demonstrate 'appropriate behaviour' are allowed a small number of take away doses as a form of 'reward', while individuals who fail to demonstrate 'appropriate behaviour' by not adopting appropriate 'technologies of the self' are denied this privilege. These 'appropriate behaviours' are outlined in the agreements consumers are required to sign when commencing on pharmacotherapy programs and usually include stipulations such as

that they not enter dispensing pharmacies in the company of another person. Agreeing to regular urine testing, to determine if consumers are using substances other than those that they are prescribed, are another common feature of these agreements. The ability of pharmacotherapy consumers to travel outside their 'treatment area' is restricted by factors such as the need to organise alternative prescribing, monitoring and dosing regimes. The aim of these agreements is to produce individuals who 'are subject to a regime of rationalised administration, making them into passive, acquiescent subjects who even co-operate in their own subordination' (Cuff et al. 1990:277). These surveillance technologies constitute what Campbell (2004) argues are 'technologies of suspicion' which she describes as

> interlinked forms of political rationality that organize activity, strategy, and technology in relatively "homogenous" ways. Practical systems are interlinked systems of relations or connections between the control of things; actions upon others (which Foucault would later call governmentality or the "conduct of conduct"); and relations with oneself. Drug testing regimes are designed to monitor, verify, and regulate the "conduct of conduct" - the effect of their deployment is a climate of suspicion (Campbell 2004:81).

These surveillance technologies were previously identified by Castel who noted that 'surveillance can be practised without any contact with, or even any immediate representation of, the subjects under scrutiny' (1991: 288). This serves to further undermine the prospect of consumers engaging in partnerships in any meaningful way.

Bourgois (2000:180) describes the 'repressive micro-logistics' of dosing that takes place in methadone clinics in the USA and how dispensers order 'recalcitrant addicts' to open their mouths and demonstrate that they have swallowed their dose in an attempt to prevent diversion to the street market. He also describes the activities of security officers and police in areas surrounding dispensaries. Much the same practices operate in Australia where, as in many other countries, methadone is commonly referred to by consumers as 'liquid handcuffs' (Fraser and Valentine

2008). I consider the mix of covert and overt forms of disciplining behaviour and constant surveillance described in these studies fit neatly within a Foucauldian framework – a phenomenon I consider has given rise to a 'pharmaceutical panopticon'.

Further evidence of surveillance and the pharmaceutical panopticon relating to the methadone program in Tasmania can be found in a research project funded by the National Drug Law Enforcement Research Fund, the Illicit Drug Reporting System (IDRS). This project is conducted each year in all capital cities and interviews people who use illicit drugs, as well as a range of alcohol and other drug service providers and law enforcement personnel, seeking information about patterns of drug use and drug availability. In Tasmania, the IDRS is coordinated within the School of Psychology at the University of Tasmania, further underlining the dominant pathologising discourse relating to illicit substance use. While consumer input is sought into developing this research to identify local priorities, this is problematic in Tasmania where no peer-based organisation is able to adequately represent the views of illicit drug users. In such an environment, measuring the effectiveness of either law enforcement or harm reduction initiatives can only be, at best, 'guesstimates' as alluded to by Miller (2001:176).

This research has regularly found that Tasmania has significantly higher rates of methadone injecting than any other state, both by people on the program and those who obtain doses diverted to the illicit market (Breen et al. 2004). One result of this has been an increased focus on the methadone program by law enforcement and health officials, as well as politicians and anti-drug lobbyists. This has resulted in increased police activity around the major methadone dispensing pharmacies, primarily aimed at reducing the diversion of take away doses to the illicit market. The 'currency' of take-away doses also means police are often deployed to reduce standover tactics to force consumers to hand over their take away doses. This police activity also provides another means of surveillance of those on the program as well as those seeking to obtain it through the unregulated market of the streets. Again this resonates with the ethnographic study of methadone consumers and the concept of

disciplining addictions posited by Bourgois (2000) and further underlines the utility of Foucault's notion of governmentality for understanding contemporary illicit drug policy and the concept of the pharmaceutical panopticon this gives rise to.

The 'Tasmania *Together'* document released in 2001 provides further evidence of the governmentality focus on methadone in Tasmania (TTCLG 2004). This document set a number of targets aimed at improving the health and wellbeing of all Tasmanians, symptomatic of a governmentality approach to maximising the utility of the resource of population. Among these targets was a reduction in the number of new entrants into the methadone program arguing that this would indicate a reduction in the number of people addicted to opiates. The 'Tasmania *Together'* document states

> *In Tasmania the number of new entrants who are on the methadone program are generally addicted to prescription drugs. A decrease in the number of people addicted to prescription drugs would indicate a decrease in the levels of addictive behaviour* (TTPB 2006:40).

Somewhat ironically the 'expert body' of 'community leaders' that developed this 'whole of government' document overlooked the fact that methadone is both addictive and available only on prescription. The arguments of Szasz (1974) and Bourgois (2000) relating to medicalisation and methadone discussed earlier provide a useful theoretical framework for understanding this.

Although 'Tasmania *Together*' was touted as a 'whole of community' process this target was set with no consumer input, and no consultation with clinical staff in the alcohol and other drug sector (Jackson 2006). This is contrary to the principles of partnerships and 'the participatory imperative' (Petersen and Lupton 1996:147) that I argued in the previous section are a feature of 'The New Public Health' and a governmentality approach to managing the issue of substance use. Upon review of this target, after a five year period, the Tasmania *Together* Progress Board claimed this target had been met and it was subsequently dropped from future documents (TTPB 2006). Sure enough, the target of a reduction in the number of new entrants to the program had been achieved, however, this was due to the program's incapacity to

take on new clients as well as a concerted effort to prescribe new clients buprenorphine instead of methadone, regardless of the wishes of the client and without any clinical indication that this was the most suitable form of treatment (Jackson 2006). This resonates with the Foucauldian notion of what 'truths' count as authorative (Foucault 1994c) as discussed in Chapter Two. This failure to consult with consumers, in a formal policy process aimed at strengthening communities, is indicative of a systemic failure to meaningfully engage people who use illicit drugs in partnerships, in spite of the rhetoric of a range of policy documents and acknowledged 'best practice'. It further supports Friedman's (1998) argument about the political economy of scapegoating illicit drug users and his view that in a political climate of prohibition their 'collective right and capacity to be involved in decision-making and interventions around compliance issues and around therapy development is simply not discussed' (Friedman 1998:18). Further, it again highlights the fact that pharmacotherapy programs are a rational neoliberal governmentality technology for surveillance and control of deviant populations and fit neatly within the framework of a pharmaceutical panopticon.

3.8 The Politics of Evidence

Evidence-based policy is another defining feature of neoliberal governmentality approaches to rule and is a commonly used rhetorical tool in the drug policy arena. Such an approach to policy development is symptomatic of a rational approach to governing, however, research shows that evidence is subject to political and moral factors and far from a scientific value-neutral approach to rule (Berridge and Thorn 1996; Hughes 2007; Marston and Watts 2003a, b; Pawson 2006; Ritter 2009; Zajdow 2004). As discussed previously, what is of interest to governmentality researchers is what knowledges count as authoritative and are adopted as truths because of their efficacy in supporting government objectives (Gordon 1994:xviii). Foucault argued

> in societies like ours, the "political economy" of truth is characterized by five important traits. [These include] 'the scientific discourse and institutions that produce it; … it is produced and transmitted under the

> control, dominant, if not exclusive, of a few great political and economic apparatuses; … it is the issue of a whole political debate and social confrontation ("ideological" struggles) (Foucault 1994c:131).

Following Foucault's reasoning Rose argues that

> once political power takes as its object the conduct of its subjects in relation to particular moral or secular standards, and takes the wellbeing of its subjects as its guiding principle, it is required to rationalize itself in particular ways (Rose 1999:7).

With this in mind it is important to understand the rationalities by which government's seek to justify the adoption of one type of evidence in preference to another. In terms of Australian illicit drug policy this can prove somewhat difficult, however, as there are numerous contradictions evident in how government approaches this issue. As I discuss in more detail in Chapter Five, one such contradiction is the Howard Government's stated "Tough on Drugs", zero tolerance policy approach while continuing to support the expansion of needle and syringe programs (Macintosh 2006; Treloar et al. 2006; Wodak 2004).

Pawson (2006) argues that 'modern polities are a balancing act between hierarchical privilege, economic power, ideological standpoints and democratic mandates' (2006:1) and the area of drug policy in Australia demonstrates all these features. As discussed above, people who use illicit drugs, at least at problematic levels, tend not to possess political power, nor do they usually aspire to (ANCARD 1999). As a result their role as experts, or in Foucault's terms 'specific intellectuals' (Foucault 1994c:129), capable of providing evidence that can influence policy is limited. Approaches to reducing drug related harms in the community are generally polarised between ideological standpoints of zero tolerance and harm minimisation and those supporting the former have gained significant leverage in the Australian drug policy community in recent years (Fitzgerald 2004; Hoare 2004; Macintosh 2006; Mendes 2001, 2008; Moore, M 2004b; Rowe 2004a; Rowe and Mendes 2004; Wodak and Moore 2002). Additionally, Australia's democratic system of government, as in many

other Western democracies, means that many politicians are loathe to take an alternative stand on drugs that is based on a rational, evidence-based approach for fear of alienating their electorate and losing power (Coomber 1998; Hartnoll 1998; Wodak and Moore 2002). It has been argued that 'the process of changing a failed policy is complicated by the fact that the public health benefits of reform are delayed beyond the current electoral cycle, while the political costs are immediate' (Wodak and Moore 2002:9). It is also argued that 'evidence-based policies are much harder to sell politically because they sound counter-intuitive. But the strong empirical support for harm reduction and drug law reform is increasingly difficult to deny' (Wodak 2005:41). In regard to the continued emphasis on law enforcement approaches ANCARD argues that 'not only is policing expensive: the best international evidence casts doubt on its efficacy' (1999:138). More recently this has been recognised in the *Vienna Declaration*, which calls for national governments and international bodies such as the United Nations to 'implement and evaluate a science-based public health approach to address the individual and community harms stemming from illicit drug use' (ICDSP 2010).

In Australia, as in many other Western democracies, however, there appears to be a reluctance to gather evidence through supporting research that may lead to findings that do not sit well with the ideological perspectives of those in government and concerns about how this may affect their chances at the ballot box. The vetoing of the proposed heroin trials by former Prime Minister Howard, in spite of support from State Health and Police Ministers, is one example of this

> The quashing of the heroin trials in the Australian Capital Territory was a direct result of pressure applied by the Executive of the Commonwealth Government in response to a perceived lack of community support for the trials. The incident demonstrates a lack of political commitment at the national level to ensuring that the most comprehensive range of treatment options is available to people who inject drugs (ANCARD 1999:140).

In such a climate it is apparent that far from being a rational approach to rule, political expediency and moral considerations are significant factors in the policy process, equal to or greater than any sound scientific evidence. As Rowe argues 'when politics and morality are entwined, rational 'evidence-based' arguments are often subordinated to populist perceptions, regardless of whether these are accurate' (Rowe 2004b:119).

Ritter (2009) argues that there are

> substantial influences upon policy other than simple decision-making driven by research evidence. These are the politics, power and pressure groups and opportunistic policy windows that can drive decision-making (2009:71).

The political nature of what counts as evidence has also been noted by Marston and Watts (2003a, b) who argue that the concept of evidence-based policy is little more than a 'fad' and a rhetorical tool adopted by neoliberal governments, along with other concepts such as 'mutual obligation' and 'social capital' to divert attention from the increasing inequality in income evident in Australia (Marston and Watts 2003a:32). Within neoliberal regimes evidence is valorised as something 'neutral' and 'objective' and beyond the realms of ideological perspectives. By conveying a sense of science and rationality, government policy making is seen to address social problems identified and researched by 'experts'. As has been discussed previously, a defining feature of a neoliberal governmentality approach to rule is a reliance on such experts.

Marston and Watts argue that policy making 'is an irreducibly linguistic and political process' (Marston and Watts 2003a:43) and the identification of social problems and problematic groups of people is contentious and subjected to differing power relations and ideological viewpoints. They argue that 'being in a position to speak the 'truth' can therefore be as important as what constitutes the truth' (Marston and Watts 2003b:146), this is very much akin to Foucault's theoretical perspective on power/knowledge discussed in the previous chapter (Gordon 1994; Lupton 1995; Petersen and Lupton 1996). Elsewhere it has been argued that research in the alcohol

and other drug sector can be subjected to political processes which raises ethical concerns among researchers (Miller et al. 2006). Similarly, Hughes (2007) argues that while evidence-based policy is promoted as the ideal in drug policy development within neoliberal societies, there are suggestions among public policy researchers that evidence is used selectively to support predetermined policy objectives. This is supported by the view expressed by ANCARD that: 'A refusal to implement a range of measures supported by convincing international evidence reveals a tendency to ignore the public health aim of harm minimisation' (1999:140). With this in mind Hughes suggests that it might be more appropriate to consider the concept of 'policy-based evidence' rather than 'evidence-based policy' as a key factor in the development of illicit drug policy (Hughes 2007). In such a politically contested environment, the prospect of meaningfully engaging people who use illicit drugs in partnerships is significantly undermined and the unique expertise they offer in terms of reducing drug related harms remains largely unutilised.

3.9 Conclusion – The Utility of Identifying a 'Suitable Enemy'

In this chapter I have argued that, for the most part, contemporary policy approaches to illicit drugs and the 'New Public Health' project of partnerships involving people who use illicit drugs can be understood within a governmentality theoretical framework. However, I have also argued that, far from being a value-neutral, rational approach to managing illicit drug use, a range of moral and political issues impact on this. These factors have contributed to the failure to realise an 'ideal governmentality' approach to drug use as I proposed in the opening chapter.

As I argued in the previous chapter I consider that in order to better understand how this situation has arisen, and the reasons a prohibitionist approach has continued to be the dominant discourse relating to substance use resulting in the limited success of such partnerships, a broader perspective is needed. Again, I find Friedman's (1998) argument about the 'political economy of scapegoating' a valuable augmentation of a governmentality framework of analysis. This political economy perspective has also

been adopted to some extent by Bourgois (2003) in relation to 'crack' users and by Fraser and Valentine (2008) in their study of participants of methadone programs.

A growing body of research indicates that the current prohibitionist approach to certain drugs has created greater harms than the use of drugs themselves. The costs associated with law enforcement and imprisonment of drug offenders continue to increase, while there is scant evidence that this has been effective in reducing drug related harms or drug use (Bourgois 2003; Drucker 1999; Hathaway 2002; O'Malley and Mugford 1991b; Rowe 2004b; Werb et al. 2010; Wodak and Moore 2002; Wodak and Owens 1996). Webster (1999) argues that the current prohibitionist approach is a 'perverted instinct' and that 'many comparable irrationalities and social pathologies were long ago laid to rest through the influence of our modern age of science and reason' (1999:53). He argues that the continuation of 'prohibition is not 'rational policy' designed to bring the best results to the greatest number' (Webster 1999:61). Similarly, Rowe (2004b) argues that we are on the brink of a 'policy paradigm crash' (2004b:116) and this will eventually lead to a situation where policy makers will have to look at alternative approaches to the current prohibitionist discourse based on rational, sound scientific evidence.

So what is the rationale behind the global prohibition of certain types of drugs?

Room (1999), in relating the proceedings of the United Nations Commission on Narcotic Drugs, describes the links made by delegates between drugs and terrorism. He notes the proliferation of the neologism 'narcoterrorism', as well as the metaphorical description of drugs as a 'scourge', a 'menace', a 'monster' and a 'bane' (Room 1999:1692-1694). He argues that

> various industries with products that might come under question on health or social policy grounds - alcohol, tobacco, armaments, perhaps even pharmaceuticals - have an interest in international attention remaining focused on a clearly demarcated set of prohibited products, while they get on with the business of opening markets for their products (1999:1705).

Room also suggests that, since the Cold War, drug policy has become an ideal arena in which former combatants can reach some form of consensus. Utilising a concept developed by Christie (1986), Room argues that 'illicit drugs are "suitable enemies" for the modern state: a fearsome and intangible opponent against which to rally solidarity'(1999:1704) MacGregor shares this view arguing that drugs 'can serve as the glue which anti-communism previously provided: new parties, new alliances can be welded together with the flame of anti-drugs rhetoric' (1999:81).

Similarly, when arguing for the utility of such a 'scapegoating' approach, Levine (2002, 2003) contends that governments across the world 'have found drug prohibition *useful for their own purposes*, for several reasons' (2002:169 emphasis in original). The reasons he lists include: increased police and military powers; an increased emphasis on individual responsibility for health and economic success consistent with neoliberal principles; increased media profits from the sensationalist stories the 'war on drugs' generates and perpetuates; and an increased capacity to use state powers to police morality and regulate daily life (Levine 2002, 2003).

Others have argued that prohibition has its roots in historical xenophobia and fear of 'the other' (Bourgois 2003; Bunton 2001; Coomber 1998; Manderson 1992, 1993; O'Malley and Mugford 1991b; Rowe 2001; Webster 1999). These views seem contradictory to an enlightened liberal approach to rule based on rational, scientific calculation whereby the role of government is to maximise the utility of the resource of population in order to strengthen the state's economy, 'at a distance' and through 'freedom' (Rose 1999). It is in this discursive environment that the concept of partnerships involving people who use illicit drugs has failed to have any significant impact on efforts to reduce drug related harms and is why I consider a governmentality framework requires augmentation for understanding this situation.

Chapter 4 - Research Design and Method

4.1 Introduction

In this chapter I discuss the approach adopted in the research to examine the concept of partnerships involving people who use illicit drugs in the policy development and service delivery planning processes. I also discuss some of the ethical and practical issues encountered when conducting the research as well as reflect on my role in the research process and how this may have impacted on the findings.

4.2 Research Methodology

The methodology employed for the research was a two-pronged qualitative approach and comprised analysis of policy documents as well as in-depth interviews with key stakeholders who were members of the Australian 'drug policy community' (Fitzgerald and Sewards 2002). This dual approach was chosen in light of the critique by McKee (2009) that governmentality studies had a tendency to disregard empirical reality due to a focus on discourse as opposed to a 'social realist' approach to policy analysis. McKee perceived a tendency to focus primarily on government documents which has resulted in 'a disconnection between the study of specific mentalities of rule and the social relations in which they are embedded' (2009:473). She saw this as posing problems for understanding 'the effects of power at the micro-level and the lived experience of subjection' (2009:474). McKee proposed a strategy for overcoming this was to adopt what she described as a 'realist governmentality' approach by 'complementing discursive analysis of emergent governmentalities with localized empirical accounts of actual governing practices' (2009:478). This involves using ethnographic approaches alongside analysis of government policy documents to show how policies actually play out in the real world. Such an approach illuminates 'the contingent and particular national, sub-national and micro-level factors that may shape universalistic governmental rationalities' (2009:480). It is with this in mind that I elected to incorporate a Critical Discourse Analysis approach of various government texts with an ethnographic study of members of partnerships involving people who

use illicit drugs in my research. This dual approach 'opens up a critical space in which to explore how central 'plans' are mediated from below and the way in which projects of rule are applied differently in different places' (McKee 2009:480). This is particularly relevant for one of the key aims of my research in which I analyse factors that have contributed to the failure to establish a viable and sustainable illicit drug user advocacy organisation in Tasmania, while such organisations have prospered in other States.

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advocacy organisation in Tasmania, while such organisations have prospered in other States.

The method employed for the analysis of the documents was partly Foucauldian inspired analysis, in addition it also utilised elements of Critical Discourse Analysis. A Foucauldian approach was taken to place the policy development process within a genealogical, or 'history of the present' context and provide a better understanding of the factors which have contributed to contemporary approaches of addressing the issue of drug related harms. At the same time, elements of Critical Discourse Analysis were adopted to analyse the discursive practices and rhetorical strategies adopted in relevant policy documents to produce and maintain the social reality of drug problems and the strategic responses to these.

As one of the key theoretical orientations of the research was Foucault's concept of governmentality it was imperative to analyse 'the changing discursive fields within which the exercise of power is conceptualised' (Rose and Miller 1992:175). The research illuminates the political rationalities, a key concern of governmentality scholars, which foster and utilise various forms of knowledge and expertise and the institutional and vocational location of those authorised to make truth claims relating to illicit drug use. Such an approach enables illumination of the exclusionary procedures of neoliberal regimes and how, by establishing regimes of truth, they 'not only exclude themes, arguments and speech positions from the discourse, but also produce outsiders, denounce groups of people as sick, abnormal or irrational, and grant other groups the right and legitimacy to treat these people' (Andersen 2003:3). The historicising approach inspired by Foucault also enabled the analysis of discontinuities or 'ruptures' evident in drug policy, such as the erosion of the principles of harm minimisation and a discernable shift towards a "Tough on Drugs" zero tolerance approach.

By adopting a Critical Discourse Analysis approach the research analysed the processes and structures that impact on the formulation of contemporary harm minimisation policies in the field of illicit substance use. Critical Discourse Analysis

seeks to 'explore the relationships between text, discourse and context [and] how the socially produced ideas and objects that populate the world were created in the first place and how they are maintained and held in place over time' (Phillips and Hardy 2002:6) Critical Discourse Analysis is also concerned with uncovering the rhetorical devices and ideology which influence the production of various discourses (Lupton 1992), and 'plays an advocatory role for groups who suffer social discrimination' (Meyer 2009:15) making it a useful tool for policy analysis. Such a discursive approach is helpful in social policy analysis as it 'can help to uncover how the use of language is connected to broader processes and practices, such as the reproduction of social relations or the construction of knowledge' (Hastings 1998:192). The use of language 'almost always occurs in a discursive context reflecting relations of power and domination' (Atkinson 1999:61). Critical Discourse Analysis 'intervenes on the side of the dominated and oppressed groups and against dominating groups, [and] openly declares the emancipatory interests that motivate it' (Fairclough and Wodak 2004:358). As such, this research analyses the various power relations in play in the illicit drug policy arena and aims to give voice to those subjugated knowledges that are largely excluded from the policy development process.

This approach to analysing the texts was chosen above other possible methods, including traditional discourse analysis and ethnomethodology, as I consider the critical component of such an approach better situates the research to offer a more sophisticated critique of contemporary approaches to drug policy. Fairclough argues that traditional textual analysis 'lacks a developed social orientation in failing to consider how relations of power have shaped discourse practices and in failing to situate … discourse historically in processes of social struggle and change' (1993:15). He argues that traditional approaches have a tendency to treat texts as finished products with inadequate attention paid to the processes of production and the tensions and contestations inherent in such processes (1993:2). Fairclough considers ethnomethodological approaches as similarly 'non-critical' with a tendency 'to avoid general theory, and discussion or use of concepts such as class, power or ideology' (1993:17).

4.3 Selection of Texts

Adopting a genealogical approach, the research analysed Tasmanian and National illicit drug policies and strategic plans as well as other relevant documents, such as HIV/AIDS and hepatitis C (HCV) strategies, which informed the development of these policy documents. The documents selected for analysis dated back to 1985 when the National Campaign Against Drug Abuse (NCADA) signalled a significant shift in Australia's approach to illicit drugs with the adoption of 'harm minimisation' as official government policy. The research analysed discernable shifts in the focus of these policies, such as the adoption in 1997 of the "Tough on Drugs" policy approach introduced by the Howard Coalition Government. The research adopted a Critical Discourse Analysis approach to examine the rhetorical strategies adopted in the documents, focusing on key concepts such as 'partnerships' and 'consumer participation', and examined how these concepts relate to the reality of policy implementation and practise. By looking at a number of related texts, such as the HIV/AIDS strategies, as well as reports from House of Representatives Committees, it was possible to identify changes that have occurred within these discourses over time, as well as make sense of the social and political context within which these discourses have been produced (Phillips & Hardy 2002:6).

Every National Drug Strategy (NDS) document released during the period from 1985 to 2005 was analysed as part of the research process. In total four National Drug Policy documents were analysed, as well as the *National Action Plan on Illicit Drugs* – a key document released during the tenure of the Howard Government. In addition the five National HIV/AIDS, two National hepatitis C strategies and the three Tasmanian Drug Strategies were also analysed. Finally, two key reports from House of Representative Committees also formed part of the corpus of texts analysed as a key focus of these reports were illicit drug use, as is discussed in more detail below. I considered it important to analyse each of these documents in order to develop a

comprehensive genealogy of the concept of partnerships involving people who use illicit drugs. [2]

As these policy documents and strategic plans form the primary basis for decisions about the allocation of funding to various organisations, thus facilitating 'governing at a distance', I consider they represent critical fragments of genealogical evidence for research of this nature. The subtle differences between 'harm reduction' and 'harm prevention' in such documents may appear on the surface to be minor nuances but reflect significant shifts, or ruptures, in discourse in the illicit drug policy arena. The funding to organisations that support the ideology of the Federal Government generally reflects this view, as I discuss in later chapters. This makes the Critical Discourse Analysis approach I have adopted in the analysis of these documents particularly useful in research such as this. Every National Drug Strategy (NDS) document released during the period from 1985 to 2005 was analysed as part of the research process. In total four National Drug Policy documents were analysed, as well as the *National Action Plan on Illicit Drugs* – a key document released during the tenure of the Howard Government. In addition the five National HIV/AIDS, two National hepatitis C strategies and the three Tasmanian Drug Strategies were also analysed. Finally, two key reports from House of Representative Committees also formed part of the corpus of texts analysed as a key focus of these reports were illicit drug use, as is discussed in more detail below. I considered it important to analyse each of these documents in order to develop a comprehensive genealogy of the concept of partnerships involving people who use illicit drugs. [3]

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[2] When Labor came to power in late 2007 there was a lengthy delay in the release of their first Drug Strategy – which was eventually released in early 2011 - so it was unable to be included as part of this research.

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4.4 Analysing the Texts

Analysis of the relevant policy documents was a critical component of the first stage in the research process and informed the development of interview questions and probes for the second stage of the data collection process. In this way the themes and issues identified in the policy documents could be further explored through in-depth interviews with key informants. During this process it was important to keep in mind that while no single document provides a complete picture, when considered as a whole they begin to reflect a dominant discourse and provide the researcher with a sense of continuities and ruptures. The data in these documents was initially coded using an open coding process (Rice and Ezzy 1999; Silverman 2005) as key themes, categories and rhetorical devices emerged. This process has been described by Kendall and Wickham as 'the examination of bodies of statements in the archive'(1999:29). The data was then further scrutinised and subjected to a process of 'focused' or 'selective' coding (Dey 2004) that enabled the initial categories to be reduced to a more easily managed set of categories consistent with the theoretical concepts I wished to explore (Marvasti 2004; Rubin and Rubin 2005).

4.5 Key Informant Interviews

Interviews with key informants involved in policy development and service delivery planning, as well as with members of peer-based organisations that advocated on behalf of consumers of illicit drugs, served to 'triangulate' the findings from the analysis of the policy documents. Triangulation is a process by which 'the same issue is investigated in a variety of ways so that different types of evidence are produced to support a particular finding' (Minichiello et al. 1999:45). This approach enabled greater insight into the machinations of the policy development process and provided a richer set of data than could be gathered simply by the analysis of a sample of policy documents or, alternatively, by just electing to interview people who were members of what Fitzgerald and Sewards (2002) describe as 'Australia's drug policy community'.

The sampling strategy for recruitment has been described as 'purposive' as it aimed to gain insights into the experience of people working in different capacities within partnerships. Purposive sampling enables a 'full and sophisticated understanding of all aspects of the phenomenon' (Rice and Ezzy 1999:42) under investigation. Purposive sampling requires the researcher to 'think critically about the parameters of the population we are studying' (Silverman 2005:129) in order to ensure that it illustrates features of the issues that are of interest to the researcher. Silverman (2005) argued that it is also important to seek out 'deviant cases' to search for negative instances which serve to test out a theoretical perspective. My sampling approach ensured I included such cases, including policy makers from law enforcement agencies and service providers from government agencies, as opposed to community based service providers who I considered might be more inclined to challenge existing paradigms. Conversational partners – as they have been described by Rubin and Rubin (2005) – were recruited from Victoria, New South Wales (NSW), the Australian Capital Territory (ACT) and Tasmania. The rationale behind choosing these States was because both Victoria and NSW have long established, government funded, peer-based drug user organisations. The ACT did have a funded peer-based organisation at the commencement of the research, however, during the course of the project funding was withdrawn and then subsequently reinstated almost a year later. Tasmania remains the only State in Australia not to have a funded peer-based drug user organisation, although there have been several groups which formed then eventually disbanded during the past two decades. A key focus of the interviews was to try and understand the different factors behind why some States were able to sustain peer-based organisations and others not.

In total 15 people were recruited to be interviewed. Four were from NSW, three from Victoria, two from the ACT and six from Tasmania. All had been working in some capacity in the illicit drug sector for a minimum of ten years, some of them in a number of different States, as well as at a national and international level. Those recruited were either contacts I had established during my time working in the illicit drug sector or, in some cases, on the recommendation of these people, using what has

been described as a ‘snowball’ approach (Liamputtong and Ezzy 2005:47; Rice and Ezzy 1999:45). Those interviewed included policy makers, service providers and workers from peer-based drug user organisations. It should be noted that in some cases these people worked in more than one capacity within these partnerships. The nature of Australia’s ‘drug policy community’ means that people are often involved in both policy development and service delivery, and in the case of some of the people working with user organisations their work meant they fitted into all three cohorts.

Interviews were conducted using an approach based on what Rubin and Rubin (2005) describe as responsive interviewing. A similar perspective on interviewing by Holstein and Gubrium (2004) described such interviews as “active interviews”. Rubin and Rubin’s model relies on a mix of interpretive constructionism and critical theory and is shaped by the practicalities of conducting interviews. The aim of this style of interviewing is to create depth of understanding rather than breadth and requires the research design to remain flexible throughout the course of the research (Rubin and Rubin 2005:30). Responsive interviewing requires the interviewer to reflect on their role throughout the interview and be aware of how their views might influence the interview process. In responsive interviewing the interviewer ‘establishes the general direction of the project [however], the conversational partners set the more specific path’ (Rubin and Rubin 2005:33). Rubin and Rubin use the term ‘conversational partners’ as this emphasises the active role they play in the discussion and the direction that it takes. In this way both participants are able to reached a shared understanding of the issues being discussed (Rubin and Rubin 2005:14). This approach recognises the unique traits each person has and enables the researcher to gain insights into their distinct knowledge and experiences enabling a deeper understanding of the research topic.

Prior to the interviews participants were sent a one-page sheet outlining some of the themes that might be explored, but emphasising that much of the discussion would relate to their own experience of partnerships. Each interview started out with the same question “In your experience how successful has the involvement in partnerships of people who use illicit drugs in policy development and service

delivery planning processes been?" The responses to this initial question then guided the direction of the conversation towards the individuals' own experience of working in partnerships as this differed among each of the conversational partners. This enabled the conversational partners to elaborate on a range of topics, thereby providing insights into the real life experience of working in partnerships that I may have otherwise not been aware of. My role as the researcher was to pick up on points of interest and by use of a series of probing questions explore them in more depth.

In effect the interviews constituted an ethnographic study focussing on the experiences of people working in partnerships as part of their role within the 'drug policy community'. Their involvement in this 'community' qualifies them as members of what Rice and Ezzy (1999:154) describe as a 'cultural group'. Ethnography is considered an effective strategy to 'emotionally engage, educate, and move the public to action' (Tedlock 2005:473) which is a key aim of this research. Ethnographic research differs from other forms of research in that 'rather than 'studying' people, the ethnographer attempts to 'learn from the people'' (Liamputtong and Ezzy 2005:165). By adopting an ethnographic approach I was able to gather a rich description of the 'culture' of the policy making and service development environments and acquire insights into the involvement of people who use illicit drugs in this process (Liamputtong and Ezzy 2005:174).

The interviews were all conducted face-to-face as I feel that the responsive interviewing approach I adopted is not well suited to telephone interviewing due to the somewhat impersonal nature of this technique. Interviews ranged in length from 45 minutes to 2 ½ hours and were recorded using a digital voice recorder. I personally transcribed the interviews verbatim using Microsoft Word. While somewhat laborious I considered this process enabled me to immerse myself in the data from the earliest stages of analysis and aided in the identification of any significant patterns in the data as they emerged.

4.6 Analysing the Interview Data

When embarking on this research project I searched the literature for an approach that I felt would assist with understanding the concept of partnerships involving people who use illicit drugs. I initially became interested in the concept of grounded theory as developed by Glaser and Strauss (1967) which had gained increasing popularity in the qualitative research field. However, I had concerns with the view that a grounded theory approach eschews existing theory and seeks to develop new theoretical perspectives while the research is being conducted. I subscribe to the view that to think that a researcher enters the field as a *tabula rasa*, without any preconceived theoretical perspectives or leanings, is somewhat naïve. All researchers have some preconceptions that they bring to their research and the important thing is to consciously avoid these preconceptions impacting on observations and theory building (Dey 2004; Ezzy 2002). The nature of developing a dissertation such as this means that the researcher has to immerse themselves in a wide body of literature to determine the direction their research will take. Strauss and Corbin (1990) acknowledge that literature reviews often form an important initial stage in developing grounded theory. Further, in describing the coding process used in grounded theory, Ezzy argues that 'codes do not emerge from the data uninfluenced by preexisting theory' (2002:93). Silverman (2005) also argues that the 'omnipresence of theory' and the need to have at least some sense of the research orientation means that a 'naturalist' approach can often lead to 'sloppy, unfocused research' (2005:79). With these doubts in mind I was always conscious of the fact that my research could not help but be influenced by the background reading I had done during my literature review or by my professional experience working in the policy development and service delivery arena.

During the course of my literature review I encountered Foucault's concept of governmentality and read a number works that adopted this approach. This struck a chord with me as a useful theoretical framework for researching the concept of partnerships involving people who use illicit drugs. This was largely due to my background working in a variety of positions within government and non-government

agencies across a variety of chronic disease areas where the concept of partnerships with consumers was central to policy development and service delivery planning processes. Evidence of a governmentality approach was becoming apparent during my analysis of the various policy documents that formed one component of the data for my research. I become increasingly aware that I would struggle to avoid the preconceptions I had developed through this process and employ a grounded theory approach that was truly faithful to this methodology. It was critical to develop some familiarity with these policy documents before interviewing those involved in 'partnerships' in order to be able to discuss aspects of them that I anticipated might arise during the interview process. In addition, my sampling method for choosing interview participants was somewhat constrained by my decision to do all interviews face-to-face and the limited budget I had for travel. This did not lend itself to the theoretical sampling that is regarded as an integral part of a grounded theory approach (Charmaz 2005:510; Liamputtong and Ezzy 2005:265) and was another factor in my decision not to use this approach in spite of the appeal it held for me. I did, however, employ a number of the techniques commonly used in grounded theory such as inductive coding, although this was done in conjunction with deductive coding, due to the interest I had developed in looking for evidence of a governmentality approach in the data.

Having decided that a grounded theory approach was not going to be suitable for the purposes of my research I was attracted to the responsive interviewing model proposed by Rubin and Rubin (2005) which shares some similarities with grounded theory but places more emphasis on explicitly linking data analysis with pre-existing theories. I was also influenced by the cultural studies approach that interprets data within broader social contexts and 'explicitly integrates theoretical questions as part of the data analysis process' (Ezzy 2002:104). I was also influenced by the techniques of thematic analysis that enabled me to identify emerging themes from the interviews during the analysis process that indicated evidence of a governmentality approach in the development of drug policy.

Coding and analysis of the interview transcripts was done manually as I felt this would enable nuances in the texts to be more readily identified. Further, I felt the investment of time and effort required to evaluate, learn and exploit the capabilities of the range of qualitative analysis software packages available would detract from the investment in developing the theoretical component of the research - perhaps a reflection of my views on positivist quantitative approaches to public health policy. I was also mindful of the caution advised by Willis that 'to use computers in the coding of qualitative data takes away the creative element and mechanises a process that relies on the researchers' understanding of context in interpretation' (2006:268). Adopting a thematic analysis approach, the interview transcripts were first coded using an open coding process (Ezzy 2002:88; Rice and Ezzy 1999:195-196). The themes identified through this process enabled the development of inductive codes (Willis 2006:266). The data was then further scrutinised and subjected to a process of 'selective' or 'focused' coding (Charmaz 2003:320; Ezzy 2002:87) which enabled the initial conceptual labels to be reduced to a more easily managed set of analytic categories. These categories were *'positive'* and *'negative'* perceptions of partnerships, *'barriers'* and *'enablers'* and *'Tasmanian specific issues'*. Another analytic category, coded as *'other issues',* was also created as the data under this heading, while in some instances relating closely to the *'barriers'* category, covered a broader range of issues relating to drug policy at more of a macro level than those that focused on barriers to partnerships at a local level. Willis notes that it can sometimes be the case that data initially coded as 'other' actually become a category in its own right (Willis 2006:266). Within this last category there were a number of sub-categories. It was on these six analytic categories that the foundations were built for testing the utility of a governmentality theoretical framework for understanding partnerships involving people who use illicit drugs, a theme that was contemporaneously emerging from the analysis of the various policy documents.

4.7 Ethical Issues Relating to the Research Process

Ethics approval was gained through the University of Tasmania's Human Research Ethics Committee, ethics approval number H9163. Those interviewed as part of the

research were provided with an information sheet outlining the research and asked to sign a consent form stating that they understood the purpose of the research. The consent form signed by interviewees gave permission to publish findings of the research provided that participants could not be identified as participants. Participants were also offered the opportunity to review written transcripts of the interviews although none elected to take up this offer.

During the course of the research a number of ethical issues were encountered. In order to protect their anonymity, all participants in the interview process were given an assurance that none of the information provided could be traced back to them. Given the relatively small size of the 'drug policy community', particularly in Tasmania, this presented some difficulties. A number of issues covered during the interviews were of such a nature that the person discussing them could have been identified had this been included in the findings of the research. Also, several of the Tasmanian participants mentioned specific individuals who they believed had impeded the establishment of a viable peer-based user organisation in this State. In order to protect them, and myself, from possible legal action I elected to not include this information in my findings. Another respondent spoke at some length about one of the original members of the ANCD who identified as a member of a drug user organisation. After some time discussing the political nature of appointments to the ANCD this person then checked themselves and asked that I not include the information discussed as they felt they did not have permission to speak about this individual's involvement with the ANCD. I gave an undertaking to not include this part of the discussion in the interview transcript. While I don't consider these factors impacted significantly on the quality of my research it did highlight for me the potential ethical minefield of conducting research of this nature.

4.8 Researcher Effects

Research of this nature can never be completely value neutral. Charmaz argues

> no analysis is neutral - despite research analysts' claims of neutrality. We do not come to our studies uninitiated. What we know shapes, but does not necessarily determine, what we "find" (Charmaz 2005:510).

The life experiences of the researcher cannot help but impact on the direction of inquiry or the interpretation of the findings of the research. Liamputtong and Ezzy argue 'the results of a qualitative research project are integrally influenced by the theories, emotions, morals and politics of the researcher' (2005:283). As this research is concerned with the 'politics of prohibition' and the stigmatisation and marginalisation that result from this, the emancipatory approach adopted could be perceived as biased towards the interests of people who use illicit drugs. However, as this research shows, their voices are rarely heard in policy debates and this research illuminates their perspective of working in partnerships, as well as the perspective of others who work with them.

In the research I adopt some of the methods of Critical Discourse Analysis due to the appeal it holds for me based on my experience of working in various roles in policy development and service delivery planning processes in both government and non-government sectors. During the literature review process I encountered numerous examples of applied Critical Discourse Analysis and it struck a chord with me as a useful analytical tool for better understanding partnerships at a practical level. The process of developing these documents as the official government position on an issue is typically overseen and refined by 'expert bodies' ('Steering Committees', 'Working Parties' or the like) before they are signed off by the Minister (or Ministers) responsible for implementation of the policy. These 'expert bodies' are typically made up of senior officials from a range of government and non-government agencies and, in some cases, consumers. These bodies ensure policy reflects the views of the incumbent government and seek to impart ideological messages through the use of rhetorical devices, such as 'partnerships' and 'affected communities' (Hastings 1999; Lupton 1992). These bodies are also often sites of contestation and compromise, where power and 'expertise' generally hold sway. My experience working in this area

provides me with insights into this process that undoubtedly influenced my choice of method.

I make no pretence that this research is not influenced by my views on the folly of the 'politics of prohibition' nor do I seek to hide my desire that, in some small way, this research might contribute to the growing choir of voices that are calling for a different approach to the issue of drug use in society given the well documented failure of prohibition and the significant harms caused by this approach (Hathaway 2002; ICDSP 2010; TDPF 2010; Wodak and Moore 2002). This research is intended to highlight the fact that the concept of partnerships involving people who use illicit drugs is, in most instances, little more than a rhetorical tool aimed at portraying a policy process in line with contemporary public health best-practice of inclusiveness and consultation. If improved health outcomes among users are to be achieved they need to be meaningfully engaged in all aspects of the policy process, although the structural and environmental barriers resulting from prohibition makes this difficult. This research identifies some of these barriers and offers some solutions as posed by those affected and others who work in these partnerships. As Rubin and Rubin highlight, research of this critical nature seeks to 'redress past oppression, bring problems to light, and help minorities, the poor, the sidelined and the silenced' (2005:25).

My interest in the concept of partnerships involving people who use illicit drugs stems from many years working in various government and non-government organisations, as well as in the private sector, in a variety of roles relating to a range of health issues. During this time I witnessed some very effective partnerships involving consumers of health services. This experience spanned the area of illicit drug use as well as the more 'respectable' areas of chronic disease and gay men's health. I was privileged to be involved in a number of public health partnerships where consumer input to policy development and service delivery planning was valued and considered an essential element in achieving better health outcomes. At other times, however, I witnessed instances where the concept of partnerships and consultation with consumers was regarded as something of an inconvenience and mere 'lip service' was given to

genuine consumer involvement. During my time working in the illicit drug sector I had been invited to attend meetings of two of the now defunct user groups in Tasmania in an advisory capacity, one of these groups also had a police officer regularly attend meetings in a similar advisory role. Furthermore, my interest in researching this topic has meant that I have had the privilege of attending several conferences and Annual General Meetings conducted by AIVL as a Tasmanian delegate. This is due to the inability to recruit suitable 'peer' delegates from Tasmania to these events as a result of the stigma attached to identifying as an illicit drug user and the implications this has in a small jurisdiction. It was this experience that motivated my research into this topic. In this regard the research is influenced by the critical theory approach discussed by Kincheleo and McLaren (2005) which advocates that researchers 'enter into an investigation with their assumptions on the table, so no one is confused concerning the epistemological and political baggage they bring with them to the research site' (2005:305-6).

My involvement in the area of illicit drugs in a professional capacity facilitated the recruitment of a number of conversational partners working in peer-based drug user organisations, or having had experience working with them in Tasmania, that would otherwise have not been possible. At the same time I sensed my previous experience working with people who use illicit drugs meant some of the conversational partners working in law enforcement and service delivery roles were a little suspicious of my motives and appeared somewhat guarded at the commencement of the interviews. In most cases this appeared to dissipate not long after the interviews were underway and it became clear to the conversational partners that my research was motivated by a genuine interest in the practical workings of partnerships involving people who use illicit drugs. I anticipated this and in an effort to overcome this participants were sent a list of questions that might be discussed in advance, they were also advised that the interviews would focus on their own involvement in partnerships and that not all questions would be relevant to them. Given my background I was also wary that participants might simply seek to convey views about partnerships that they thought I wanted to hear. The open-structured nature of the interviews allowed me to encourage

conversational partners to relate their views on partnerships in their own terms and to structure their stories according to their own experience. I am confident that during the interviews the conversational partners became so engaged with providing their own views of the workings of partnerships involving people who use illicit drugs that any desire to provide a particular perspective of partnerships they thought I might want to hear was minimised.

4.9 Concluding Remarks on the Research Process

In this chapter I have discussed the approach I took in the research process to analyse the role of people who use illicit drugs in partnerships. I identified the theoretical framework that guided my inquiry, as well as the methods used for gathering and analysing data about the topic and the reasons why I adopted the approach I did. I also discussed some of the ethical issues encountered while conducting the research, as well as the possible impact that my own background and beliefs may have had on the conduct and the findings of the research. In the next few chapters I discuss the findings from my analysis of various policy documents, as well as the interviews conducted as part of the research process to support my argument that the concept of partnerships involving people who use illicit drugs is primarily a rhetorical tool used by neoliberal governments to convey a sense of inclusiveness of affected communities.

Chapter 5 - A Genealogy of Partnerships in Policy Documents

5.1 Introduction – Governmentality and Partnerships

This chapter has two primary objectives. Firstly it analyses a range of relevant national policy documents and strategic plans relating to illicit drugs. I also analyse two reports written by the House of Representatives Standing Committee on Family and Human Services released in the late stages of the Howard Government's tenure. These documents demonstrate evidence of government practices and policies aimed at reducing the harms related to illicit drug use consistent with a governmentality approach. The various 'expert' bodies responsible for developing these documents, and changes in the structure of policy advisory bodies also form part of this analysis. In this chapter I also analyse Tasmanian policy and strategy documents relating to illicit drug use as well as national documents relating to HIV/AIDS and hepatitis C (HCV). This is important as it was within the context of HIV/AIDS that the notion of partnerships involving people who use illicit drugs was first developed in Australia. I also discuss some of the limitations that are apparent when applying a governmentality framework of analysis to the drug policy arena. The second objective is to trace the evolution of the concept of partnerships involving people who use illicit drugs in policy development and service delivery planning. This second component supports my argument that the concept of partnerships is largely a rhetorical device used by neoliberal governments to address social problems. The concept of partnerships in the social policy arena is a common feature of neoliberal regimes and a growing corpus of research has utilised a discourse analysis approach to look at various aspects of partnerships (Atkinson 1999; Coleman 2004; Hastings 1996, 1998; 1999:53). The subsequent two chapters adopt an ethnographic approach to determine how the concept of partnerships espoused in these documents matches the reality of 'partners' experience in policy development and service delivery processes in Australia over the past 25 years.

In this chapter I utilise Foucault's theoretical framework of 'governmentality' and adopt a Critical Discourse Analysis approach to trace discursive shifts relating to

illicit drug use at a national level. My focus is on those documents, and specifically on relevant sections of them, that represent significant benchmarks in the evolution of the concept of partnerships involving people who use illicit drugs. As discussed in Chapter Two, Foucault's notion of 'governmentality' provides a bridge between his theories of social control and 'technologies of the self' making it useful for understanding how government seeks to shape the conduct of subjects under its sphere of control (Foucault 1994a; Petersen 1997; Turner 1997). Governmentality, or 'the art of government', relies on utilising a range of experts and technologies that support the administrative structures of the state in facilitating the management of the 'resource' of population. These technologies include developing a range of surveillance mechanisms and the establishment of various 'expert bodies' to support the state in this endeavour. In this chapter I discuss some of the strategies and technologies adopted in the drug policy development process to support my argument that the concept of 'governmentality' is a useful tool for the analysis of this process, I also discuss why I consider such an approach has limitations.

The methodology employed adopts the 'historicizing' approach utilised by Foucault (Hall 2001:74) and also utilises elements of Critical Discourse Analysis. A Foucauldian approach places the policy development process within a genealogical, or 'history of the present' context and provides a better understanding of the factors that have contributed to contemporary approaches to address the issue of drug related harm. At the same time, elements of Critical Discourse Analysis are adopted to analyse the discursive practices and rhetorical strategies adopted in the various documents to produce, maintain and reproduce the 'threats' illicit drug use poses to society and the strategic responses to these. Such a discursive approach is helpful in social policy analysis as it 'can help to uncover how the use of language is connected to broader processes and practices, such as the reproduction of social relations or the construction of knowledge' (Hastings 1998:192).

5.2 The evolution of drug control in Australia

Drug control efforts in Australia have been through a number of distinct phases since European settlement (Macintosh 2006; Manderson 1993). From the first white settlement through to the late 1800's drug use was considered largely a matter of personal choice with few formal controls in place (Macintosh 2006; Manderson 1992, 1993). The second phase, from the late 1800's to the second decade of the 1900's, saw laws passed which, according to Manderson (1993), were largely based on racist attitudes towards Chinese immigrants who smoked opium, and which sought to protect Aboriginal people and the white colonial community, particularly women, from the evils of such practices. Also, in the early 1900's an international drug control regime began to emerge and Australia became signatory to a number of international agreements (Macintosh 2006; Manderson 1992, 1993).

The next phase, from the second decade of the 1900's to the 1960's, saw an expansion of international control regimes, largely driven by the USA and Great Britain, and a great deal of pressure was placed on Australia to adhere to a range of treaties and conventions. This saw a number of prohibitions placed on drugs such as cannabis, cocaine and heroin that were considered to lead to degeneracy and moral failing (Macintosh 2006; Manderson 1993). The fourth phase from the 1960's onwards saw a further expansion and consolidation of the various international agreements, as well as a number of domestic drug control measures, ostensibly targeting major drug traffickers rather than individual users (Macintosh 2006; Manderson 1993), however, criminal sanctions remained in place which sought to reduce the incidence of individual illicit drug consumption.

The impetus behind the more recent development of a national drug policy is argued by Macintosh (2006) to be related to an increase in illicit drug use in the 1960's and 70's, particularly among young people. The use of illicit drugs was 'linked to a young and decadent lifestyle that posed a threat to the moral fabric of society and the authority of law' (Macintosh 2006:15). While dependent drug users began to be viewed more sympathetically and were more likely to be viewed as suffering from an

illness, 'the social stigma of being a drug user remained' (Macintosh 2006:15; Manderson 1993). At the same time drug policy began to become highly politicised, with politicians of every ilk eager to be seen to be taking an active stance on controlling drugs and drug use, based on the premise that being 'seen to be doing something about drugs was an essential element of every political platform and a short-cut to popularity' (Macintosh 2006:14; Manderson 1993:146). Another contributing factor was the consolidation and expansion of international drug control regimes, which played a significant role in raising awareness of drug issues and impacting on public attitudes towards drugs (Macintosh 2006; Manderson 1993).

5.3 Towards Contemporary Drug Control – The Early Years

In the following sections of this chapter I analyse the evolution of a national approach to managing the issue of illicit drug use and develop a genealogy of the concept of partnerships involving people who use illicit drugs evident in these documents. Since 1985 the Federal Australian government has developed a number of policies relating to both licit and illicit drugs as well as HIV/AIDS and HCV. The first of these policies, *The National Campaign Against Drug Abuse* (NCADA) (DOH 1985:3), signalled a significant change with the adoption of harm minimisation as official Government policy. Subsequent policies have sought to build on the concept of harm minimisation, albeit in a climate of considerable contestation of the meaning of this term.

The first NCADA document was released following then Prime Minister Bob Hawke's tearful public admission that one of his own children had problems with heroin. This resulted in the Australian Labor Party (ALP) pledging to develop a comprehensive response to the issue of drug addiction and abuse if re-elected in the upcoming Federal election. Following Labor's re-election the Prime Minister convened a Special Premiers' Conference which resulted in the adoption of Australia's first comprehensive national drug strategy (Fitzgerald and Sewards 2003:198; Macintosh 2006; Manderson 1993).

A number of passages in the NCADA document (DOH 1985) demonstrate that a governmentality approach is evident in strategies targeting illicit drug use. Some key features of a governmentality approach include: the development of a range of surveillance technologies dispersed throughout the social body; reliance on a range of 'experts', often outside the formal apparatus of government, to develop effective responses to social issues; and the use of responsibilising language to exhort all subjects of government (including individuals, organisations and various government agencies) to contribute to the overall goals of the state (Bunton 2001; Rose et al. 2006a). In this section I discuss some of the statements contained in this document to demonstrate the utility of a governmentality framework for analysing contemporary approaches to drug control in Australia utilising Critical Discourse Analysis and Foucauldian inspired methods.

The use of 'responsibilising' language aimed at shaping 'the conduct of conduct' is a key feature of neoliberal governmentality discourse at both the level of the individual and the wider community (Fraser 2004; Garland 1999; O'Malley 1996). The subjects of government are expected to develop the necessary 'technologies of self' to enable them to make the greatest possible contribution to the state (Dean 1995; O'Malley 1999b:201-204). In his work on government unemployment programs Dean (1995) describes 'practices of governmental self-formation' and 'the ways in which various authorities and agencies seek to shape the conduct, aspirations, needs, desires and capacities of specified political and social categories' (1995:563) while at the same time defining 'rights, obligations and statuses' (1995:567). Within this discursive environment individuals and organisations empowered by such government programs but who fail to take prudential measures and make informed choices about the harms related to drug use are then liable to be seen as failing to meet their obligations as responsible citizens (Petersen 1997:198), whether corporate or individual, leaving them open to a range of interventions and sanctions. This responsibilising discourse applies not only to individuals, but also organisations and government bodies as I discuss below.

Examples of this responsibilising discourse can be found in the introduction to the first NCADA (DOH 1985) document which states that *'the success of the Campaign would depend upon full co-operation between the States and the Commonwealth'* and that the Campaign *'should be launched as a co-operative effort, and that all Governments would devote additional resources to this vital task'* (DOH 1985:1). By exhorting all levels of government to co-operate in addressing illicit drug use, the Campaign identifies all relevant government agencies as responsible for the overall success of the Campaign. Utilisation of the concept of a 'whole of government' approach for implementing government projects is a feature of neoliberal governmentality approaches to rule, whereby the risks associated with such enterprises are dispersed throughout the social body and a range of authorities are entrusted with, and as a result responsible for, the task of policy implementation (Bunton 2001; Rose 1996c). Another example of this responsibilising discourse is the following statement: *'A national approach is essential with co-operative effort and mutual support across jurisdictional boundaries'* (DOH 1985:3) again exhorting all levels of government to take responsibility for addressing drug problems in the community. Such exhortations are necessary due to Australia's system of government whereby States and Territories are largely responsible for delivering health and community services. The Australian system of government also means that each State and Territory has responsibility for enacting laws relating to the use of drugs and these differ from one jurisdiction to the next. The Federal Government, however, maintains the power to veto individual jurisdictional initiatives, as was the case with the heroin trials proposed in the ACT.

At the level of individual subjects of government, further evidence of a governmentality approach can be found in the section outlining the education initiative which aims at *'helping people make informed responsible decisions about drug use and promoting self-help and positive alternatives to drug use'* (DOH 1985:3). Again this reflects a responsibilising discursive approach whereby the subjects of government are expected to develop the necessary 'technologies of self' to resist the uptake of drug use (Dean 1995; O'Malley 1999b:201-204). Again this is

consistent with the 'practices of governmental self-formation' described by Dean (1995) as has been discussed previously.

Another feature of a governmentality approach is the way in which government seeks to problematise life and deploy a range of expert bodies and state-sanctioned authorities, often not directly linked to the apparatus of government, to address social problems and develop a range of strategies and technologies for acting on them (Bunton 2001; Rose 1993). This serves to further extend the networks of surveillance throughout the social body rendering a population more amenable to a range of interventions. A governmentality approach is also dependent on the development of rational technologies of government by which the state can make the objects of government 'knowable'. This enables government to adopt an actuarial approach to managing populations (O'Malley 1996) by establishing a variety of surveillance technologies which make behaviours, as well as the interventions aimed at modifying these, calculable. The following statements in the NCADA document, in the section outlining the 'underlying principles' of the Campaign, again illustrate the utility of a governmentality framework for the analysis of drug policy in Australia

> *A major emphasis should be to strengthen the capacity of existing institutional and other community structures to deal with drug abuse' and 'Reliable data for monitoring programs, the development of new approaches and evaluation of programs are required (DOH 1985:3).*

This eventually gave rise to the establishment of National Research Centres in Sydney (The National Drug and Alcohol Research Centre), Perth (The National Drug Research Institute) and Adelaide (The National Centre for Education and Training on Addiction). It also led to the establishment of the National Drug Law Enforcement Research Fund as well as a range of State-based research organisations and treatment services.

The introduction to the NCADA document also states that *'the Campaign would focus particularly on the problems associated with those drugs which are illegal'* (DOH 1985:1) while acknowledging that widespread harms are associated with the abuse of

licit drugs. This indicates that while ostensibly the campaign purports to be adopting a new health focused approach to the management of drug problems it continues to operate within a prohibitionist paradigm. This is reiterated in the third underlying principle of the NCADA document which contains the following statement *'Particular attention ... needs to be given to those drugs the use of which is illegal in our society'* (DOH 1985:3). Again this reflects the fact that drug policy continues to operate within a prohibitionist framework, seeking to bring about a desired end of abstinence, or in the language of governmentality scholars to guide 'the conduct of conduct' (Gordon 1991:48). This indicates that all illicit drug use is considered pathological, with no acknowledgement that many people do use illicit drugs without any apparent harmful effects. It also reflects a conservative moral view of drug use whereby any level of illicit drug use is considered a moral failing on the part of the individual.

The fifth underlying principle of NCADA is *'The emphasis should be on demand reduction programs, but this should interrelate constructively with attempts to control supply'* (DOH 1985:3). This recognises that efforts to eliminate drug use and availability will never be completely successful thereby reflecting an actuarial approach to managing drug use which is considered to be a defining feature of governmentality (O'Malley 1996; Rose 2000). While seeking to shape the conduct of citizens through demand reduction measures, such as education programs about the harmful effects of drugs, the Campaign maintains the role of law enforcement approaches at the forefront of the Government's response to drug use. This is consistent with Foucault's notion of 'a total structure of actions brought to bear upon possible actions' (Foucault 1982:220).

The NCADA document then goes on to provide a comprehensive description of the major initiatives involved in the Campaign and the primary aims of these initiatives. These four initiative areas are: education; treatment/rehabilitation; research and information; and controls and enforcement.

Developing training programs and support mechanisms for professional and lay workers in the health, education and welfare sectors is another initiative of the NCADA campaign (DOH 1985:5-6). Once more this is consistent with a governmentality approach whereby a range of 'experts' from outside the formal state apparatus are dispersed throughout the social body. This serves to enhance the web of panoptic surveillance technologies at the disposal of the state as well as the range of practices that can be deployed in the efforts to create prudential, risk calculating subjects and to identify those who fail to adopt such prudential behaviours (Rose 1993; Turner 1997).

Another initiative of NCADA was the enhancement of treatment and rehabilitation programs for those people with problematic drug use (DOH 1985:5). Again this initiative is intended to create a body of 'experts' dispersed throughout the community with a range of technologies, such as pharmacotherapy programs, at their disposal. Under this initiative it is proposed that some innovative treatment and rehabilitation programs will be developed, without specifically saying what these might be. The document then goes on to emphatically state that *'Heroin as a treatment for opiate dependence is not supported'* (DOH 1985:5). This statement reflects the fact that, in spite of the efforts to implement programs based on rational scientific evidence, there continues to be a strong component of political expediency and conservative morality in many aspects of drug policy.

The idea of heroin substitution as a treatment modality was, and continues to be, an unpalatable option for many conservatives with the capacity to influence drug policy. At the time the NCADA document was released there was little available evidence about the efficacy of heroin maintenance as a treatment modality. However, as such an idea is dismissed out of hand, this statement suggests that moral and political considerations played a significant role in shaping drug policies, as much then as they continue to today. This is consistent with what Dean (1998) describes in his work on unemployment programs as 'a certain kind of political logic rather than to any explicit governmental rationality' (1998:87-88).

The NCADA document then goes into more detail regarding methadone programs, listing it among a range of drug-free options as acceptable treatment modalities. Methadone maintenance is seen as a means of assisting opiate dependent persons to *'adopt a normal lifestyle, and to reduce crime'* (DOH 1985:6) suggesting that contemporary drug policy is influenced by 'the governance of *risk generated by drug dependency*' (O'Malley 1999a:204). It also reflects what Dean refers to as 'governmental-ethical practices' (1995:562) whereby

> 'practices of government' come to depend upon, operate through and create relays and linkages with what might be called 'practices of the self' (1995:562).

The next section of the NCADA document covers the area of research and information, identifying the need for improved data collections for informing progress of the Campaign as well as for estimating levels of drug use in the community. It also calls for enhanced evaluation of programs with the aim of improving outcomes. Again, for the purposes of analysis, this can be situated within a theoretical framework of governmentality. As has been discussed previously, governmentality requires the development of a range of surveillance technologies to support the administrative structures of the state and inform decision-making processes. By collecting a range of data on a variety of interventions governments are in a better position to make informed decisions about the optimum use of finite resources. This seeks to make drug use thinkable in new ways and enables it to be subjected to new forms of governance, namely risk management or what O'Malley refers to as 'actuarialism' (1999a).

The next section of the NCADA document covers the area of 'controls and enforcement'. It calls for a uniform and consistent approach to legislation, particularly regarding classification of drugs, offences and penalties. It states that

> *Within penal provisions emphasis will be placed on traffickers, including those behind the scenes; there will be provision, in appropriate cases, for the diversion of user-offenders for treatment* (DOH 1985:8).

This ostensibly signifies a change in emphasis whereby the main target of law enforcement is traffickers rather than users, and the proposed introduction of diversion initiatives for users supports this claim. Diversion programs, however, still treat illicit drug use as pathological, as well as criminal, indicating that moral concerns about personal drug consumption still dominate the Australian approach to this issue.

The NCADA document then goes into more detail about proposed law enforcement strategies. Reference is made to 'expert' bodies such as the National Crime Authority and the utilisation of joint task forces to target drug trafficking. Mention is also made of the use of telephone interception powers and the strengthening of computer processing capabilities to support law enforcement efforts. This is again consistent with the governmentality literature whereby the state deploys a range of expert bodies and state-sanctioned authorities to address social problems (Bunton 2001; Rose 1993) and utilises a range of surveillance technologies for acting on them.

Targeting drug traffickers, as opposed to users, also represents a discursive shift in drug policy debates. Recognising that the illicit drug trade is an enormously profitable industry meant that politicians, to some extent at least, were able to divert attention from laws aimed at individual users and instead focus on a new threat to the moral fabric of society, the 'Mr Big's' of the drug trade who were making huge profits from the peddling of human misery (Manderson 1993). The NCADA document outlines a range of measures that it proposed to introduce, such as the confiscation of assets, again reflecting the governmentality concept of the use of a range of surveillance technologies for maintaining social control. However, it is naïve to think that curbing the activities of traffickers will result in a cessation of drug use, particularly when a range of social factors contribute to an individual's use of illicit drugs. Manderson argued that politicians were able to use this new menace, 'Mr Big', to their advantage as it 'drew attention away from the weaknesses of the structure of drug legislation itself and towards its populist façade' (1993:188).

The final section of the NCADA document deals with international aspects of the drug trade, including obligations under international treaties as a member of a range of United Nations bodies, and proposes a range of measures to support Australia's efforts in this area. Again this reflects a governmentality approach to drug policy where the state works in collaboration with other sovereign states to share expertise and surveillance technologies in the name of tackling drug abuse and trafficking. It is this area of drug policy where geopolitical influence and notions of morality have perhaps their greatest impact, specifically the influence of the USA which adheres rigidly to a prohibitionist approach to drugs and uses a range of means, including the threat of economic sanctions, to try and influence other countries to adopt this approach.

In this section I have utilised a Critical Discourse Analysis approach to analyse the language contained in the text and the systems of knowledge and power relations that impacted on this process and argued that the NCADA document demonstrates a governmentality approach to managing drug related harms. The document itself, at only ten pages long, is somewhat small in comparison to subsequent policy and strategy documents but marks the nascence of a governmentality approach in this area of social policy, one that became more evident in later years. The reliance on 'expert bodies', a 'whole of government approach' and the development of a range of surveillance technologies to support the implementation of the Campaign being some key examples of this.

Notably, the NCADA document makes no mention of partnerships involving people who use illicit drugs. This concept did not enter drug policy discourse in Australia until the first HIV/AIDS Strategy released in 1989. In the first *National HIV/AIDS Strategy* 'the need for a strong and supportive partnership' (DCSH 1989:3) is identified as a key component of Australia's response to HIV/AIDS. This document sets out roles and responsibilities of all members of the partnership, including non-government organisations and individuals, again utilising the responsibilising language that is considered a key feature of a governmentality approach, as discussed above. The document recognises that organisations representing the interests of

people who inject drugs play a key role in responding to the HIV epidemic through a range of activities such as peer education as well as *'representing the particular needs of their members and liaising with government and private sectors'* (DCSH 1989:7). The document also states that *'members of the target groups and community-based organisations will be involved in developing and implementing programs'* (DCSH 1989:31). This is the first official policy document to recognise that people who use illicit drugs have a specific expertise and is the beginning of the concept of partnerships involving drug users in the policy process in Australia.

5.4 The Keating years

The next policy document I analyse in this chapter is the *National Drug Strategic Plan 1993-97* (NDSP) developed while the ALP was still in power at the Federal level, albeit under a change of leadership with Paul Keating having replaced Bob Hawke as Prime Minister. An evaluation of NCADA in 1992 led to it being renamed the National Drug Strategy (NDS) and all Commonwealth, State and Territory health and law enforcement Ministers, who made up the Ministerial Council on Drug Strategy (MCDS), endorsed the National Drug Strategic Plan in that same year (Single and Rohl 1997:3).

This document was launched under the banner of 'The Drug Offensive', conjuring up the metaphor of a battle against the evils of drug use and abuse. The use of such metaphors has been argued to be a common tool used by those in power to legitimise their policies (Charteris-Black 2005). The introduction to the NDSP maintains a commitment to continuing a harm minimisation approach. It claims that the NCADA has made significant achievements since its inception and has gained a 'high international reputation' for Australia as a result of its 'balanced and comprehensive approach' (DHHLGCS 1993:1). The format of the NDSP represents an increased sophistication in governmental approaches to drug policy, and policy documents, by setting out a range of strategic goals and objectives, as well as setting a number of key indicators that will enable progress against the various objectives to be measured. Again this reflects a key feature of a governmentality approach to rule whereby social

problems and responses to them are made calculable, using the network of surveillance technologies developed for this purpose, and reporting the findings of these enterprises to a range of 'expert' bodies. It also reflects a change in the nature of funding for service providers whereby outcome based contracts became the norm under neoliberal governments and such indicators enable measurement of these contracted provider's performance.

The context for the NDSP is set out in the second section under the heading *'Major Issues'* which outlines the economic and social costs of alcohol and drug abuse, including health care and law enforcement costs as well as loss of productivity, it also sets out the priority areas to be addressed in the latest national strategy. As discussed previously Foucault argued that an essential element in the establishment of the art of government was 'the introduction of economy into political practice' (Foucault 1994a:207). In order to maximise the potential of a population to contribute to the economy it needs to be made amenable to a range of interventions and these need to be quantifiable. The manner in which this document sets out the economic costs of drug use supports this contention.

Section 3 of the NDSP outlines the policy approach to be adopted under the new Strategy. It restates the Government's commitment to harm minimisation and provides a more detailed description of what such an approach entails. This reflects the contested nature of harm minimisation, whereby morally conservative critics have argued that there is little or no room for abstinence-based approaches under harm minimisation and the priority should be on preventing the uptake of drugs in the first place – as was seen in the USA with the 'just say no' approach. The NDSP explicitly points out that abstinence is but one of a number of approaches that sit under the umbrella of harm minimisation. This also reflects the recognition by government of the need to balance the competing political and moral agendas of those involved in policy development processes if something resembling a consensus on illicit drug policy is to be reached. As I discuss later in this chapter, the debate around abstinence-based approaches has been a hotly contested one. This debate came to the fore under the Howard regime where 'drug warriors' manoeuvred themselves into a

position which gave them significant political leverage and influence through their appointment to various advisory bodies.

Section 3 of the NDSP document also outlines '*the importance of a broad spectrum of control measures* [aimed at restricting] *importation, manufacture, trafficking and use of certain substances'* (DHHLGCS 1993:4). Responsibility for implementing such controls is spread across a broad range of stakeholders, including law enforcement authorities, health authorities, professional bodies and community groups. As discussed above a governmentality approach seeks to deploy a range of expert bodies and state-sanctioned authorities, often not directly linked to the apparatus of government, to address social problems and deploy a range of strategies and technologies for acting on them, further extending the networks of surveillance throughout the social body (Rose 1993).

This section of the NDSP also calls for an *'intersectoral approach'* and *'collaborative effort'* as a key component in addressing alcohol and drug problems. While the concept of partnerships had not yet entered the lexicon of drug policy documents in Australia, this is the first indication of such an approach being considered essential if drug control strategies are to be effective. By adopting such an approach, the NDSP argues, there will be a reduction in *'unnecessary duplication'* further it will ensure *'that existing resources are used most effectively to meet identified needs'* (DHHLGCS 1993:5). This approach is consistent with the notion of 'rational' technologies of government discussed by a number of governmentality theorists such as Turner (1997), Petersen (1997) and Dean (1995, 1999) which seek to maximise the utility of resources available for the implementation of government projects. This section also elaborates on the importance of evaluation and accountability to enable the progress of the NDSP to be measured. Again, this reflects a key feature of governmentality whereby social problems and responses to them are sought to be made 'knowable' or calculable and thereby more amenable to a range of strategic interventions.

The next sections of the NDSP document set out a number of goals and policy objectives as well as a number of priority activities aimed at meeting these objectives. Again this reflects an increasing governmentality trend towards setting measurable targets for government policy that would enable the impact of drug use to be made calculable, and the effectiveness of various interventions to be better evaluated. These sections also contain a number of activities which fit within a governmentality framework including: responsibilising activities which seek to develop personal skills among the populace to reduce drug related harms; the professional development of 'experts' to support the state in addressing drug usage; and the development of a range of surveillance technologies to make the phenomena of drug use calculable.

Section 6 of the NDSP sets out a number of priority national program activities, with a list of aims about what each activity seeks to achieve. Section 6.1 *'Personal and Professional Skills'* aims: *'To further develop public and professional knowledge, skills and attitudes regarding responsible use and intervention approaches to drug-related problems and consequences'* (DHHLGCS 1993:9). Listed under this heading are proposed aims relating to both licit and illicit drugs, however, there is a noticeable distinction between legal and illegal drugs in these proposed aims.

In relation to tobacco the document states one aim is: *'To increase the proportion of smokers who believe there are risks associated with passive smoking'* while for alcohol one aim is: *'To increase the proportion of adults who understand .... maximum responsible drinking levels .... and strategies to maintain low risk drinking'* (DHHLGCS 1993:9). This focus on the responsibilised, enterprising, risk-calculating subject, whose prudent behaviour and self-care is considered to have flow-on benefits for the wider community is a defining feature of governmentality in neoliberal regimes (Fraser 2004; Garland 1999; Lupton 1995; O'Malley 1996). This contrasts markedly with the aims under the illicit drugs category where the focus is on developing skills and knowledge of law enforcement and health professionals but no mention is made of developing skills and knowledge of people who use illicit drugs (DHHLGCS 1993:10). This suggests that this group are considered unable to adopt 'health protecting' behaviours, or in Foucauldian terms, they are not capable of

developing appropriate 'technologies of the self', and that the continued emphasis in relation to illicit drugs is on law enforcement and pathologising approaches.

In section 6.3 *'Safe and Healthy Public Policy'* the aim is: *'To enhance and implement appropriate safe and healthy public policy and legislation which promotes prevention and reduction of drug related harm'* (DHHLGCS 1993:11). This reflects a risk management, or actuarial, approach to public policy which is a recurring theme in the governmentality literature (O'Malley 1996). Again the main emphasis in this section is on developing technologies of surveillance and control, such as a range of legislative measures to eliminate advertising of tobacco products and to promote responsible advertising of alcohol, as well as disseminating law enforcement research on illicit drug markets and controlling access to products used in the manufacture of illicit drugs. It also seeks *'to increase measures to ensure that doctors prescribe pharmaceuticals appropriately'* (DHHLGCS 1993:12). This last point illustrates an underlying tension within neoliberal regimes. Whilst relying heavily on a network of 'experts' to support the state in realising its ambitions, it also seeks to put in place technologies for ensuring these 'experts' act in a manner that supports these ambitions. However, this can impact on the ability of these 'experts' to exercise their professional/clinical judgement about what best suits the needs of their patient, potentially undermining their capacity to provide optimum care.

Section 7 of the NDSP lists a range of *'key measurable indicators'* that are intended to facilitate measurement of performance against these aims. Again this approach is consistent with an actuarial approach (O'Malley 1996) whereby rational technologies of government are adopted to make the objectives of government 'knowable', a defining feature of neoliberal regimes (O'Malley 1996; Rose 1993, 2000). This section also identifies a number of priority population groups that the NDSP targets, including people who inject drugs. This is consistent with what Dean describes as the neoliberal approach of using a range of techniques to identify individuals 'capable of bearing the freedoms and responsibilities of a citizen and those, for whatever reason, are deemed not to possess the characteristics necessary for such a task' (1999:135).

As with the first NCADA document, the NDSP makes no mention of the concept of partnerships with people who use illicit drugs that were a key underlying principle of HIV/AIDS strategies during that period. The promotion of partnerships between health and law enforcement agencies was, however, cited in the evaluation of the NDS as a factor which had gained Australia a reputation as having *'one of the most progressive and respected drug strategies in the world'* (Single and Rohl 1997:viii). This evaluation also recommended that *'NDS projects should make better use of non-government organisations representing drug users, utilising their expertise in program development and the dissemination of harm minimisation information'* (Single and Rohl 1997). This was the first Government document relating to the NDS that explicitly recognised the expertise of people who use illicit drugs and the contribution they could make to policy development processes. In policy documents developed in later years, the alcohol and other drug sector began to adopt this rhetorical device in an effort to convey a sense of shared community responsibility for reducing drug related harms.

5.5 Tasmania's First Drug Strategy

The NDSP discussed in the previous section required all States and Territories to develop their own strategic plans to complement the Commonwealth's efforts – typifying the 'responsibilising' discourse discussed earlier in this chapter that is a key feature of governmentality approaches to rule. In 1996 the Tasmanian Government released the *Tasmanian Drug Strategic Plan* (TDSP). The document was developed by an inter-Departmental committee with representatives from health, education and law enforcement agencies, as well as the Alcohol and Drug Foundation from the non-government sector. The document claims to have been developed *'in partnership with the community'*, and that it will provide *'resources which facilitate communities development towards self-reliance and sufficiency'* (DHHS 1996:6). The document prioritises professional development for health workers and the development of law enforcement responses to drug use, including *'police participation in drug related policy development and activity co-ordination'* (DHHS 1996:16) but makes no mention of involving people who use illicit drugs in these processes. Among the

TDSP priorities are *'an increase in the skills and knowledge with which people may make informed and responsible decisions about illegal drugs'* (DHHS 1996:12). In governmentality terms these would be considered 'technologies of the self'. However, without any input from people who use illicit drugs it was not clear how this would have been achieved or how it would be measured. No mention is made in the document about involving people who use illicit drugs in any aspects of the plan.

In this analysis of the NDSP and related Tasmanian plan I have utilised Critical Discourse Analysis to examine the language and power structures evident in the drug policy process. I have used this approach to illustrate that the technologies and strategies adopted by government demonstrates that a governmentality approach to managing populations is evident in contemporary strategies for managing the social issue of illicit drug use. I have also argued that while harm minimisation appears to be a rational and enlightened response to illicit drug use, it remains an area of moral and political contestation and that these factors have supported the continued prohibition of certain drugs. However, the failure of a prohibitionist approach to eliminate drug use supports my argument that drug policy is far from a rational, value-neutral process. The continued pathologising and criminalising of drug use, evident through the emphasis on partnerships between law enforcement and health agencies, supports Dean's (1998) contention that political logic, rather than any genuine rational, evidence based approach, continues to dominate neoliberal social policy.

In the next section of this chapter I continue to draw upon and enact Critical Discourse Analysis to examine the *National Drug Strategic Framework 1998-2003* (NDSF) as well as other related policy documents. The NDSF was the first policy document developed by the Howard Government and the first national drug policy document to adopt the neoliberal concept of partnerships with people who use illicit drugs and demonstrates a further refinement of the notion of an 'art of government' approach in response to drug related harms.

5.6 The Howard Years

In December 1996, not long after John Howard was elected Prime Minister, the Commonwealth Government released the *3rd National HIV/AIDS Strategy* titled *Partnerships in Practice* (DHFS 1996). The document claimed to be informed by a comprehensive evaluation document widely known in the sector as the Feachem Report (Feachem 1995). The Feachem Report noted that there was frustration that the concept of partnerships *'did not live up to its goal of involving all affected communities equally'* (Feachem 1995:194). Problems relating to the stigmatisation of drug users were cited as a barrier to involving them meaningfully in partnerships (Ballard 2005:22). A subsequent review of the *3rd National HIV/AIDS Strategy* conducted in 1999 by the Australian National Council on AIDS and Related Diseases (ANCARD) found that wavering political support for harm minimisation initiatives, along with *'differing policy positions and objectives between community organisations and government on various levels have, on occasion, led to difficulties in the practice of partnership'* (ANCARD 1999:ix). This was one of the earliest indicators that partnerships with people who use illicit drugs had begun to founder under the Howard Government although, as the Feachem Report had noted, difficulties with partnerships had also been experienced under the previous Labor administration. The ANCARD review found that this wavering political support for harm minimisation and the priority given to law enforcement approaches over evidence-based public health interventions had hampered health promotion efforts targeting people who inject drugs (1999:53,137-38). The ANCARD review also noted that community-based organisations felt their involvement in decision making and policy development had been reduced, and that for people who inject drugs the effects of a prohibitionist drug policy, along with inadequate resourcing for community organisations, made it difficult for them to fully participate in partnerships (1999:132).

5.7 The National Drug Strategic Framework

The National Drug Strategic Framework (NDSF), which was released in 1998 almost 2 years after *Partnerships in Practice*, is subtitled *'Building Partnerships'* (MCDS 1998). It was the first national drug policy document released since Prime Minister John Howard launched the "Tough on Drugs" campaign in November 1997, following the vetoing of the proposed heroin trials in Canberra.

When Howard announced he was vetoing the heroin trials he argued that such a trial would 'send the wrong message' that heroin use was acceptable (Wodak 1997). The heroin trial had been approved by the MCDS and the Federal Health Minister, Michael Wooldridge, had committed Government financial support to the trial. The proposed trial had been subjected to a rigorous feasibility study over several years and sought to evaluate the applicability of such a program, which had operated successfully in Switzerland for a number of years and had been trialled in several other European countries, to the Australian context (Moore, M 2004b). Howard's veto demonstrates that ideological factors impact significantly on the drug policy process and that it is far from a value-neutral, rational approach. It was in this discursive environment that Federal policy relating to illicit drugs operated for the next decade with a variety of morally conservative, abstinence-oriented politicians, policy advisers and lobbyists having an increasing influence in the policy development process during this time.

The introduction to *'Building Partnerships'* claims a commitment to continuing the harm minimisation approach of previous phases of the National Drug Strategy (NDS) and that the recommendations of a comprehensive evaluation of the NDS (Single and Rohl 1997) are adopted in this document. The document was developed under the direction of the MCDS, comprising Commonwealth and State and Territory Ministers responsible for health and law enforcement.

In addition to the MCDS, the development of *'Building Partnerships'* was informed by a new policy advisory body established by Howard, the Australian National Council on Drugs (ANCD). This body comprised of a range of representatives from

the community sector which aimed to *'ensure that the expert voice of non-government organisations and individuals working in the drug field reaches all levels of government and influences policy'* (Howard 1998). Members of the ANCD were appointed directly by the Prime Minister. The Chairperson of the ANCD, Major Brian Watters from the Salvation Army, was a renowned advocate of zero tolerance and abstinence-based approaches to drug use. However, other initial members of the Council included a representative from the national drug user advocacy organisation, the Australian Intravenous League (AIVL) and a representative from Family Drug Support, an organisation dedicated to promoting harm reduction strategies in the drug policy arena. This diverse membership ostensibly provided a sense of inclusion and representativeness of a broad range of views, however, in subsequent years members with abstentionist views more in line with those of the Chairperson and the Prime Minister were appointed at the expense of advocates for harm reduction (Byrne 2009; DRCNet 2001).

As in the previous NDSP document a definition of harm minimisation is set out and is explicit that this approach includes abstinence-oriented interventions (MCDS 1998:1), a strategy aimed at appeasing those critics who argue, however unrealistically, that government should be aiming to achieve a drug free community. The need to define harm minimisation again signifies the contested nature of this concept. *'Building Partnerships'* claimed that the principle of harm minimisation had been fundamental to the success of Australia's Drug Strategy since it was adopted in 1985 (MCDS 1998:1).

The format of *'Building Partnerships'* continued to refine the governmentality approach to drug policy with a claim that improving *'the evidence base to better inform policy development is a priority'* (MCDS 1998:1). As with the previous NDSP this reflects a key feature of governmentality whereby social problems and responses to them are sought to be made calculable, using the network of surveillance technologies developed for this purpose, and reporting the findings of these enterprises to a range of 'expert' bodies. However, given this policy document was released not long after the vetoing of the heroin trial that aimed to collect evidence

about the viability of such a program in the Australian setting, it appears the concept of evidence-based policy is another rhetorical tool used by government to convey a sense of rationality to contentious policies, as was discussed in Chapter Three.

In the introduction to *'Building Partnerships'*, it is stated that there will be an *'emphasis on extending the successful partnership between health and law-enforcement agencies to take in a broader range of partners'* (MCDS 1998:1). A number of potential partners are then listed. A notable omission from this list of partners is people who use illicit drugs, although they were identified as partners later in the document. This continued focus on law enforcement is where I consider applying a governmentality framework of analysis to drug policy has limitations. A governmentality approach to rule is supposedly grounded in rational, evidence-based approaches to addressing social problems and there is little evidence to support the continuation of a prohibitionist approach to drugs as such an approach has done nothing to ameliorate drug related harms in society. Rather such an approach appears to be based on political logic rather than a rational approach to social problems, similar to that noted by Dean in his research on unemployment programs (Dean 1998:87).

Section 2 of *'Building Partnerships'* provides an overview of the harm caused by drugs in Australia with data on the patterns of use of both licit and illicit drugs. As in the previous NDSP *'Building Partnerships'* again outlines the economic and health costs of harmful drug use, including not only the costs to the economy through lost productivity and violence and crime but also 'intangible' costs such as the impact on family and other relationships. An overview of the intangible costs to relationships caused by drugs is then provided. The document then states that *'generational transmission of values, attitudes and behaviours contributes to higher rates of drug use in families where parents use drugs'* (MCDS 1998:13). Research is cited that had found where parents smoked cigarettes or drank alcohol their children were no more likely to use these drugs than in other families, but when parents used illicit drugs there was a far greater chance their children would use these than children whose parents did not. This effectively places responsibility for preventing drug use on

parents, and as discussed previously the use of such responsibilising language is argued by Fraser (2004), Garland (1999), O'Malley (1996) and Lupton (1995) to be a defining feature of a governmentality approach in neoliberal regimes.

For the first time in a National Drug Strategy document the issue of polydrug use, that is the use of more than one type of drug, is listed as an issue of concern. O'Malley (1999a) has argued that polydrug use poses a specific problem for government as the unpredictability of polydrug use translates into 'ungovernability' as there is no way of determining what the effects of polydrug use will be for individual users (O'Malley 1999a:200). However, as discussed previously, I consider that the prohibition of certain drugs makes all illicit drug use ungovernable as they remain outside the scope of government control, unlike alcohol and tobacco where control efforts at least have some impact on their availability and use. Also, the uncertainty of drug purity and strength that results from their proscribed status means that all illicit drug use, whether of one or more types of drug, contributes to a type of ungovernability. In subsequent policy documents the issue of polydrug use continued to be a primary focus.

'Building Partnerships' then outlines the Australian approach to reducing drug related harms and claims that an evaluation of the previous Strategy found it to be *'widely recognised as one of the most progressive and respected drug strategies in the world'* (MCDS 1998:15). One of the reasons given for this success was *'the comprehensiveness of the approach, encompassing the harmful use of licit drugs, ... illicit drugs, and other substances'* (MCDS 1998:15). Recognition is also given to the promotion of partnerships as a key factor in the success of previous strategies. This is an important passage as the evaluation conducted by Single and Rohl (1997) that is referred to, specifically mentions the role of illicit drug users as key stakeholders in partnerships but this group is not referred to here. It is also significant because in November 1997, prior to the release of *'Building Partnerships'*, the Prime Minister launched the National Illicit Drug Strategy (NIDS) titled *"Tough on Drugs"*, thus separating out licit and illicit drugs, in spite of the noted success of the previous integrated approach *'whereby the harms associated with use of tobacco, alcohol,*

pharmaceutical drugs, illicit drugs and other substances are all dealt with in a united national strategy' (MCDS 1998:22). This signified a major shift in drug policy in Australia, one that is more into line with the "war on drugs" approach of the USA.

Section 3 of *'Building Partnerships'* also reflects an actuarial approach to drug use, another defining feature of governmentality, (O'Malley 1999a) as evinced by the following passage

> *Governments do not condone illegal risk behaviours such as injecting drug use, but they acknowledge that these behaviours occur. They have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause* (MCDS 1998:16).

Harm-reduction technologies, such as the provision of sterile injecting equipment, are one of the strategies listed in this section as this is acknowledge as having been demonstrated to be effective in reducing the costs of illicit drug use to the wider community. It has also been noted that, while John Howard espoused a "Tough on Drugs" zero tolerance discourse, the continued support and expansion of needle exchange programs under his leadership is evidence that this was another rhetorical tool employed by government, while a pragmatic approach with a sound evidence base continued to shape some aspects of drug policy (Wodak 2004).

This section of *'Building Partnerships'* continues by outlining responsibility for action under the Framework, listing *'government agencies at all levels, the community-based sector, business and industry, research institutions, local communities and individuals'* (MCDS 1998:16) as having a role to play. The document then outlines what is meant by a partnership approach and lists *'affected communities (including drug users and those affected by drug-related harm)'* (MCDS 1998:17) as potential partners for the first time in an Australian drug policy document. In adopting a governmentality approach to analyse local housing initiatives in the UK, Atkinson (1999) noted

> partnerships frequently recreate existing relations of economic, social and political dependency thereby effectively perpetuating (albeit often unintentionally) the position of the disempowered (1999:63).

However, I consider that the listing of people who use illicit drugs as partners is an intentional rhetorical strategy aimed at conveying a sense of inclusion in the policy process while in reality they remain very much on the periphery, subjected to the more powerful law enforcement and health agencies in this partnership. As noted previously, McKee argued that 'political authorities remain in control of both policy agendas and significant financial resources, with community participation occurring in strictly defined parameters' (2009:475).

In Section 3 of *'Building Partnerships'* evidence that can be interpreted using Foucault's concept of biopower can be found in the following passage

> *Building Partnerships continues to seek a balance between supply-reduction, demand reduction and harm-reduction strategies, emphasising the need for integration of drug law enforcement and crime prevention into all health and other strategies aimed at reducing drug-related harm* (MCDS 1998:17).

Biopower denotes 'a specific form of governmental power which addresses the administration, control and regulation of human beings as members of populations' (Christie and Sidhu 2006:450) and which, according to Dreyfus and Rabinow 'is spread under the banner of making people healthy and protecting them' (1982:195).

Section 3 also provides further evidence of a governmentality approach to the control of illicit drugs. One passage in this section states that all

> *strategies should reflect evidence-based practice, which is based on rigorous research and evaluation, including assessment of the cost-effectiveness of interventions* (MCDS 1998:18).

Another passage states

> *Experts in the field will be consulted, national expert advisory committees will be established, approaches will be coordinated through a National Drug Research Strategy, and interested parties will be consulted* (MCDS 1998:18).

As discussed in Chapter Two, governmentality has been described as 'a mechanism for regulating and controlling populations through an apparatus of security. This governmental apparatus required a whole series of specific *savoirs* and was the foundation for the rise of the administrative state' (Turner 1997:xiii). These *savoirs* (or forms of knowledge) are dispersed throughout the social body and specific forms of power require particular forms of knowledge. This entailed the pursuit of 'rational' technologies of government through which a variety of experts and authorities utilise a variety of technologies to implement a range of projects in relation to available resources. This involves calculating both the benefits and risks of such projects, and requires the development of a variety of surveillance technologies. These expert systems cover a broad range of fields including economics, medicine, academia, and 'the management of human misery' (Rose 1993:284).

Section 4 of *'Building Partnerships'* outlines the mission and objectives of the Framework and states that a number of National Drug Action Plans will be developed under the Framework to reduce drug related harms. Such Action Plans have become commonplace in the social policies of modern neoliberal regimes, or what Dean (1995, 1998, 1999) in his research on unemployment programs has described as 'active societies' where citizens 'are made to accept responsibility for their choices' (1999:101). Again this section reflects a trend towards setting measurable targets for government policy that enables the impact of drug use to be made calculable, and the effectiveness of various interventions to be evaluated. This section also contains a number of activities that fit within a governmentality framework including: responsibilising activities that seek to develop personal skills among the populace to reduce drug related harms; the professional development of 'experts' to support the state in addressing drug usage; and the further development of a range of surveillance technologies to make the phenomena of drug use calculable.

This section goes into more detail about proposed partnerships for addressing drug-related harms and again lists a range of potential partners. The document calls for the

> *development of a closer working relationship between the three tiers of government and affected communities (including drug users, their families and those affected by drug-related harm)* (MCDS 1998:21).

This naming up of people who use illicit drugs as key partners was a primary focus of the interviews conducted in the second stage of this research in order to ascertain how the role of drug users in policy development and service planning processes was experienced by various 'partners'.

In the section of *'Building Partnerships'* headed *'Preventing use and harm'* a number of strategies aimed at preventing harmful drug use and preventing drug-related harm are outlined. This demonstrates a number of features of a governmentality approach, in particular notions of an 'active society' (Dean 1995) and a number of responsibilising statements (Fraser 2004; Garland 1999; Lupton 1995; O'Malley 1996). The following passage exemplifies this.

> *Community ownership and participation are central to the development and implementation of effective prevention programs. Communities are able to develop local responses to harmful drug use; they are not simply a target audience for public health campaigns. Individuals, families and a variety of community-based organisations need to participate in efforts to reduce drug-related harm* (MCDS 1998:26).

In the section headed *'Access to treatment', 'Building Partnerships'* outlines plans for the provision of a range of treatment services for licit and illicit drug users, from abstinence-based programs to substitute pharmacotherapies. Pharmacotherapy technologies are another example of a governmentality approach to illicit drug control and are argued to have as their main objective 'the governance of *risk generated by drug dependency'* (O'Malley 1999a:204). Methadone-maintenance programs, currently the most widely used pharmacotherapy technology in Australia, have been described as an example of biopower whereby citizens addicted to opiates are

disciplined by the requirement they submit to a strictly controlled regime of surveillance by teams of health professionals (Bourgois 2000; Fraser and Valentine 2008), a phenomenon a described previously as a 'pharmaceutical panopticon'. Heroin prescription, in spite of evidence demonstrating its efficacy in improving health outcomes for addicts (Uchtenhagen et al. 1999), is not mentioned in this section even though earlier in the document evidence-based practice is listed as an *'important policy principle of the National Drug Strategy'* (MCDS 1998:18)

Section 6 of *'Building Partnerships'* outlines the structures of the various expert bodies responsible for overseeing the implementation of the National Drug Strategy. These include the MCDS, a body made up of Commonwealth, State and Territory Ministers responsible for health and law enforcement. The Intergovernmental Committee on Drugs, comprised of senior health and law enforcement officers, as well as the Australian Customs Service and senior Education Department officials is another listed body, again demonstrating that Foucault's theoretical concepts of biopower and governmentality are particularly relevant in the drug policy arena. The ANCD, a body made up of representatives that were hand-picked by the Prime Minister, and headed during this phase of the National Drug Strategy by the staunchly conservative Salvation Army Major, Brian Watters, whose opposition to a number of progressive proposals for reducing drug related harm such as injecting rooms was widely known, is another body listed in this section. The final part of this section then lists a range of National Expert Advisory Committees, again reflecting a governmentality approach where experts, often outside the apparatus of the State, are enlisted by government to oversee implementation of its various programs (Bunton 2001).

The final section of *'Building Partnerships', 'Roles and Responsibilities',* lists a number of groups responsible for ensuring the effectiveness of the Framework. The groups listed include families and communities, community-based organisations, business and industry and the various tiers of government. This section contains a number of responsibilising statements, which as previously discussed are a defining feature of a governmentality approach under neoliberal regimes.

The section discussing *'Families and communities'* contains some of the clearest examples of this responsibilising language. The section begins with this statement

> *Responsibility for reducing the harm caused by drugs rests with all Australians. Families and communities have a vital role in the development of attitudes to and values concerning drug use. Communities and community members must take individual and collective responsibility for their own health and wellbeing* (MCDS 1998:37).

A further responsibilising passage in this section states that: *'Individuals have a responsibility to be aware of the harms that may arise from their drug use and the impact it may have on their family and community'* (MCDS 1998:37). Again this supports the argument that in neoliberal regimes individuals are made to accept responsibility for their choices (Dean 1999), they also risk a range of sanctions should they make the 'wrong' choices.

In this section I have argued that Foucault's concept of governmentality, and the further development of this concept by a number of governmentality scholars, is a useful theoretical framework for analysing drug policies in Australia. I have adopted Critical Discourse Analysis to identify the language used, the ideology and the knowledge systems in place and the power relations evident in this process. I have argued that key features of governmentality such as surveillance, responsibilisation and the deployment of expert knowledge are all evident in government policy responses to illicit drug use. I have also traced the beginning of the concept of partnerships involving people who use illicit drugs in the drug policy arena. This analysis continues with subsequent policy documents developed under the Howard Coalition government.

5.8 The 4th National HIV/AIDS Strategy

The Howard Government released the 4th *National HIV/AIDS Strategy* in 2000 and again this document recognised the important role affected communities, including people who inject drugs, play in developing effective responses to the virus. The

document states that the partnership approach it adopts is *'based on a commitment to consultation and joint decision making in all aspects of the response'* and in regard to affected communities *'re-emphasises their involvement at every level of the response – in the planning, delivery and evaluation of HIV/AIDS programs, services and policies'* (DHAC 2000a:9). The document states that

> *Initiatives will be promoted to increase user groups' capacity to design, manage and participate in peer-based prevention and health promotion activities and to participate in the broader partnership response to the epidemic* (DHAC 2000a:17).

Also developed during the period covered by *'Building Partnerships'* was the 1st *National Hepatitis C Strategy* released in 2000. This document acknowledged that the involvement of affected communities in partnerships was critical and that recognising the diversity of views and expertise people who use illicit drugs possess was a crucial element in the response to hepatitis C (HCV). It also gave a *'commitment to consultation and joint decision making in all aspects of the response'* (DHAC 2000b:12). It has been argued that partnerships in the HIV/AIDS sector had been particularly effective, citing the low levels of HIV among people who inject drugs as evidence of this, however, in more recent years this enabling environment had not translated to the illicit drug policy arena (Moore and Dietze 2005:282).

5.9 The Second Tasmanian Drug Strategy

In 2001 the Tasmanian Government released another set of policy documents under the banner of the *Tasmanian Drug Strategic Plan 2001-2004*, this included a Framework document and an Action Plan. As with the previous TDSP it was claimed to have been developed in consultation with community members (SDCC 2001), however, with no mechanism to consult with people who use illicit drugs it would not have been possible for their views to be considered. As with the previous TDSP references are made to partnerships involving law enforcement, health and local government, but again no mention is made about partnerships with people who use illicit drugs. The lack of any capacity to have input by consumers to policy and

service delivery development processes was recognised in later years by the Alcohol and Drug Service as a major systemic weakness (DHHS 2008) and a commitment was made by the Tasmanian Government to fund an organisation to facilitate this process. The organisation that successfully tendered for funding to operate this service had no previous experience working in the alcohol and other drug sector and, unlike similar advocacy services operating in other States, is not a peer-based organisation. This indicates a lack of genuine commitment on the part of the Tasmanian Government to work in partnership with people who use illicit drugs, as I discuss in more detail in the following chapters.

5.10 The National Action Plan on Illicit Drugs

In 2001, during the period covered by the NDSF discussed earlier in this chapter, the Commonwealth Government released its first *National Action Plan on Illicit Drugs 2001 to 2002-03* (NAPID). This represented a departure from previous 'integrated' approaches to drug policy where alcohol and tobacco were included with illicit drugs. This was done in spite of a recommendation in the evaluation of the first two strategies that the 'integrated' approach should continue (Single and Rohl 1997:60). This reflects the growing influence of conservative actors on the drug policy development process, as indicated by the appointment of a vocal supporter of zero tolerance, abstinence-based approaches as Chair of the ANCD and the replacement of harm reduction advocates on the ANCD by supporters of a zero tolerance approach more in line with the views of the Prime Minister (DRCNet 2001). The ANCD played a key role in developing the NAPID along with the National Expert Advisory Committee on Illicit Drugs established by the Government in 1998. The document was endorsed by the MCDS.

The NAPID document claims that illicit drug users are a *'vital resource'* in responding to drug related harms (MCDS 2001a:1). This is another indication that governments increasingly recognise, at a rhetorical level at least, the unique expertise that illicit drug users possess and, again, reflects a governmentality approach whereby a range of experts outside the sphere of government are called on to develop effective

responses to social problems. It also seeks to create a sense of inclusiveness and an enabling environment whereby people who use illicit drugs are involved in developing responses that reduce drug related harms (Moore and Dietze 2005).

As in previous policies and strategies the NAPID places a strong emphasis on law enforcement approaches aimed at reducing the supply of illicit drugs in the community. The NAPID argues that law enforcement strategies reduce demand for illicit drugs by driving up prices as well as reducing the influence of organised criminal groups (MCDS 2001a:11). However it has been argued that such an approach only results in opportunities for greater profits to be made from trafficking which, in turn, attracts more people to this enterprise (Wodak and Moore 2002:4) leading to greater levels of violence as criminal groups engage in turf wars to secure a share of this lucrative market. Other researchers have found that heroin seizures have no impact on the price, purity or perceived availability at the street level (Weatherburn and Lind 1997). The background paper accompanying the NAPID acknowledges that there was some dispute in published research about this claim, stating that *'the question remains to be settled empirically'* (MCDS 2001b:25). Again it is this aspect of drug policy that highlights the need to augment a governmentality framework of analysis. A policy based on rational evidence-based approaches would recognise these basic economic laws of supply and demand. A rational approach would seek to regulate the market in order that the state could benefit from the increased revenue that was diverted from the criminal organisations that currently profit from the illicit drug trade and effectively reduce their power base. This is where Friedman's (1998) argument about the political economy of scapegoating drug users also has merit, by diverting attention away from the inherent flaws of a free market economy and blaming society's woes on illicit drug use, the status quo is more easily maintained. Again the question of political logic versus explicit governmental rationality posed by Dean (1998) appears to be applicable here.

In the section of the NAPID headed *'Reducing drug-related harms'* a number of strategies are listed including peer education aimed at reducing the incidence of deaths by overdose. In this section *'community partnerships'* are also discussed

including partnerships between police, health professionals and local government. Notably no mention is made of partnerships with people who use illicit drugs in this section, in spite of the acknowledgement earlier in the document that they were a *'vital resource'* in responding to drug related harms. Most of the strategies discussed in this section are concerned with improving community amenity and perceptions of public safety with the police identified as having a significant role to play in this. This reflects an increasing focus on zero tolerance approaches to drug use that became more common under the Howard Government's "Tough on Drugs" discourse (McKey 1998) rather than any real intent to reduce harm among users. The omission of users from the list of members of the community partnerships is an indicator that they had become increasingly marginalised in this discursive environment.

As in several policy documents discussed previously in this chapter, there are also sections in the NAPID relating to professional development of the drug sector workforce and further investment into illicit-drug research, including enhancing monitoring of illicit drug trends, to improve the knowledge base that informs effective interventions and facilitates evaluation of these. As discussed previously these are defining features of a governmentality approach that seeks to make social problems more calculable as well as extending the surveillance network of state sanctioned authorities and experts throughout the social body.

In this section I have again argued that a governmentality theoretical framework can be helpful in understanding contemporary responses to illicit drug use. Adopting a Critical Discourse Analysis approach to analyse the use of language and the systems of knowledge brought into play, I have identified that political logic and strategising, as opposed to a rational evidence-based approach, is evident in the drug policy arena and these factors need to be considered when analysing drug policy in neoliberal societies. I also discussed how the involvement in partnerships of people who use illicit drugs became increasingly tenuous under the conservative morality based approach that began to dominate drug policy under the Howard Government. In the next section of this chapter I look at the last policy documents relating to drug use developed while the Howard Government was in power, with his statements in

support of a zero tolerance approach having led to concerns among experts working in the sector about the future of Australia's commitment to harm minimisation.

5.11 The National Drug Strategy 2004-2009

The National Drug Strategy: Australia's Integrated Framework 2004-2009 (NDS 04/09) was developed by a joint working group comprising the ANCD and the Intergovernmental Committee on Drugs (IGCD). The IGCD consisted of senior government officers representing health and law enforcement agencies in each Australian jurisdiction and representatives of the Australian Customs Service, the Ministerial Council on Aboriginal and Torres Strait Islander Affairs and the Department of Education, Science and Training. An evaluation of the previous phase of the NDS found there was a strained relationship between the ANCD and the IGCD due to 'confusion about roles and areas of interest' with the ANCD perceived to have 'upset the apparent harmony of the national drug policy making environment' (Fitzgerald 2004:51). It was felt that the ANCD had been established by Prime Minister Howard to change the model of national drug policy development by limiting the power the States and Territories had through the MCDS and the IGCD (Fitzgerald 2004). This was perceived to be in response to the MCDS support of the heroin trial vetoed by Howard and represented a shift from 'a consensual participatory model … to an executive model of policy making' (Fitzgerald 2004:53) whereby the Prime Minister could more 'directly control the drug policy arena' (Fitzgerald 2004:54). This coincided with an expanded role for the ANCD in the policy development process since its inception. As noted previously, the composition of the ANCD had moved over time from being inclusive of harm reduction advocates, including a representative of people who use illicit drugs, to a membership with a strong orientation towards faith-based abstinence approaches to reducing drug related harm rather than a sound scientific approach (Fitzgerald 2004:57; Mendes 2001) as would be consistent with a rational 'ideal governmentality' approach to social problems. This shift towards an executive model of decision making in the drug policy arena was considered to have undermined the concept of partnerships which had been a key feature of the Australian approach and created a level of distrust in the

policy community that threatened to reduce the effectiveness of the NDS (Fitzgerald 2004:59).

In spite of concerns within the drug policy community about the influence of the ANCD and increasing support by the Prime Minister for zero tolerance approaches discussed above, the NDS 04/09 maintained a commitment to harm minimisation as its guiding principle. As with previous NDS documents there are a number of passages in the NDS 04/09 which demonstrate a governmentality approach to managing the issue of illicit drug use, as well as passages which highlight the need to augment this framework of analysis.

The NDS 04/09 claimed success in building partnerships, most notably between health and law enforcement sectors, stating this *'had broadened the role of police in addressing drug issues'* and that this approach had *'significantly disrupted the supply of illicit drugs and reduced demand for them'* (MCDS 2004:2) however, this contradicts a later statement in the document which notes an increase in the use of psychostimulants over the past decade (MCDS 2004:16). It also contradicts the findings of the Australian Institute of Health and Welfare which found an increase in the prevalence of illicit drug use between 1991 and 2004 (AIHW 2005). This again begs the question of whether law enforcement approaches have a rational evidence basis, as would be expected under an 'ideal governmentality' approach, or whether such an approach is based more on ideological and moral influences on the policy process.

Again the NDS 04/09 claims to be based on the promotion of partnerships, including with affected communities, although people who use illicit drugs are not specifically mentioned in policy development partnerships. However, the document does state that the experience of consumers and drug user organisations *'should'* be included in treatment service planning (MCDS 2004:8). As in previous NDS documents the greatest emphasis in partnerships continues to be those involving law enforcement agencies and there is a continued concern with managing the impact of drug use on communities *'in cooperation with business, government and relevant media'* (MCDS

2004:9). This is largely aimed at reducing the negative effects on public amenity and perceptions of community safety resulting from illicit drug use. This reflects a 'business friendly social policy' (Shin 2000) approach consistent with neoliberal principles.

Other key features of a governmentality approach I identified when discussing previous NDS documents, including: enhancing surveillance networks; utilising a range of experts outside of the sphere of government; and the use of responsibilising language are also evident in the NDS 04/09. However, the expertise of people who use illicit drugs, which had been recognised in previous NDS documents, is not specifically identified in this document, other than that they *'should'* be included in treatment service planning as noted above. This indicates they had become increasingly marginalised in the policy development process in the discursive environment of zero tolerance. This failure to recognise the specific expertise of people who use illicit drugs is symptomatic of their diminished role in partnerships under a zero tolerance approach. Meanwhile, those who advocated abstinence-based approaches were given a much greater say in policy development and advisory processes during the term of the NDS 04/09, as is discussed below.

In the NDS 04/09 a far greater emphasis is placed on prevention, both of uptake and of the harms relating to drug use, than in previous NDS documents. This reflected growing tensions between conservative zero tolerance advocates and those committed to an evidence-based, public health approach, to harm reduction. These tensions are evident in the *'Road to Recovery'* report of the Standing Committee on Family and Community Affairs (2003) in which it was argued that the term harm minimisation might seem to *'encourage the maintenance of a drug habit and give rise to the idea take taking drugs is alright'*. As a result the Committee made a recommendation that harm minimisation be replaced with *'a focus on harm prevention and treatment'* (HOR 2003:297 cited in Rowe and Mendes 2004:7) aimed at resolving contradictions between harm minimisation and the "Tough on Drugs" approach of the Federal Government (Rowe and Mendes 2004). The *'Road to Recovery'* report was one of the

key documents that informed the NDS 04/09 and is an indicator of the discursive environment in which it was developed.

The *'Road to Recovery'* report also contained a number of recommendations that reflected the growing discourse supporting abstinence based approaches and were echoed by a subsequent Standing Committee report *'The Winnable War on Drugs'* (HOR 2007) that I discuss in more detail below. These recommendations included support for treatment programs, including methadone, which had the ultimate aim of making users drug free. A number of these recommendations were opposed by two dissenting members of the Committee on the basis that there was no scientific evidence to suggest they would be effective. This highlights the divisions between abstentionists, who are more likely to support strategies about which little or no evidence of their efficacy exists but that sit well with their moral view on drug use, and harm reduction advocates who argue for a strong evidence base before implementation of a policy or strategy can be considered. This again highlights the need to augment a governmentality framework of analysis as rational approaches to rule are not always evident in the drug policy arena.

During the term of the NDS 04/09, as well as in the earlier period covered by the *'Building Partnerships'* document, Prime Minister Howard made a number of public statements espousing how his administration supported a zero tolerance approach to drugs (Bessant 2008; HOR 2007), in spite of official Government policy remaining one of harm minimisation and some pragmatic decisions to expand funding for evidence-based harm reduction strategies such as needle exchange programs (Mendes 2008; Wodak 2004). It was in this discursive environment that proponents of abstinence-based approaches, buoyed by support from high profile tabloid media commentators, were able to voice their support for a zero tolerance approach (Bessant 2008; Hoare 2004; Mendes 2004; Rowe 2004a).

5.12 Other Strategies 2005

During the term of the NDS 04/09 a number of other relevant strategies were released, including the *Tasmanian Drug Strategy 2005-2009* (TDS). This Strategy was

developed by the Inter Agency Working Group on Drugs, a body comprising senior officials from Police, Justice, Health, Education and Premier and Cabinet Departments, as well as representation of the non-government sector by the Alcohol, Tobacco and Other Drugs Council of Tasmania (ATDC) and the ANCD. The TDS claimed to be underpinned by the concept of harm minimisation and recognised the *'importance and value of meaningful partnerships between government, non-government and local government agencies'* (IAWGD 2005:4). People who use illicit drugs were not included in this partnership. The principles that guided the TDS included *'partnerships and collaborative effort'*, however, again no mention is made of partnerships with people who use illicit drugs in this section. The failure to recognise that drug users had any role in developing effective responses to drug related harms is indicative of a culture in Tasmanian Government circles which had consistently denied this group a role in policy development and service delivery planning. Tasmania remains the only State not to have a government funded peer-based user organisation and this lack a lack leadership by the Tasmanian Government poses a significant barrier to the establishment of a viable consumer organisation in the State. This is discussed in more detail in the following chapters.

Also released in 2005 were the 5th *National HIV/AIDS Strategy 2005-2008* and the 2nd *National Hepatitis C Strategy 2005-2008.* As has been discussed previously, the HIV/AIDS sector had a long history of involving people who use illicit drugs in meaningful partnerships, and the Australian Injecting and Illicit Drug Users' League (AIVL) was recognised in the *HIV/AIDS Strategy* as having played a major role in the success of Australia's response the HIV/AIDS. The Strategy identified as a priority the need to continue to work to strengthen partnerships between governments and community-based organisations, including AIVL, and recognised the importance of involving them in decision making and policy formulation (DOHA 2005b:12). Similarly, the Hepatitis C Strategy also recognised the role of people who inject drugs as critical to the success of partnerships, once again giving a commitment to consultation and joint decision making by all members of the partnership (DOHA 2005a:11).

5.13 *"The Winnable War on Drugs"*

In 2007 the Howard Government established a parliamentary inquiry into the impact of illicit drug use headed by the House of Representatives Standing Committee on Family and Human Services, chaired by conservative Member Bronwyn Bishop. Mendes (2008) argues the establishment of this Committee was largely motivated by the failure to shift government policy away from harm minimisation towards abstinence-based approaches. The blame for this was attributed by the Committee to a group of peak bodies, researchers and non-government service providers who supported the continuation or expansion of harm reduction approaches (Mendes 2008). The Committee objected to their emphasis on *'expert knowledge'* and *'evidence-based policy'* while excluding *'ordinary people's experiences and opinions'* (HOR 2007:93). In launching a scathing attack on supporters of harm minimisation the Committee claimed that *'drug policy in Australia was thereby captured by influential drug industry elites'* (HOR 2007:93). As one of the 'elites' whose views the Committee attacked subsequently noted

> Whilst some committee members sought to distance themselves from the way in which the chairperson treated many expert witnesses, their objections were rather meek. Any reading of the transcripts and the subsequent report clearly illustrates that this was a committee led by someone with a predetermined set of outcomes underpinned by a moralistic and evidence-free base (Stronach 2007).

It is statements such as these that again demonstrate that drug policy is far from a rational, value-neutral process but one that is subjected to moral and ideological influences and political contestation and calculations.

The Committee's report, titled *The Winnable War on Drugs*, highlighted a number of conservative ideological views on a range of harm minimisation strategies that they opposed. This also served to create further confusion as to what exactly official Australian drug policy was. This was helped by the fact the Committee report was

able to quote from a speech made in Parliament by the Prime Minister on his opposition to harm minimisation

> *This government will never give up in the fight against drugs. We will never adopt a harm minimisation strategy; we will always maintain a zero tolerance approach* (John Howard, House of Representatives Debates, 16 August 2007 cited in HOR 2007:1).

This again highlights the shift in discourse that had taken place in drug policy under the Howard administration and the political rhetoric that managed to muddy the waters as to what the official Government approach actually was.

A number of recommendations made by the Committee also demonstrate a shift towards a less tolerant view of people who use drugs and a shift towards a more 'authoritarian liberalism' (Dean 2002; Hindess 2001) approach in this area of social policy. These recommendations included: that the Government *'continue its allocation of significant resources to policing activity as a highly effective prevention method'* (HOR 2007:xxi); that adoption be the default option for children where a child protection notification involved illicit drug use by parents (HOR 2007:xxii); that Government

> *replaces the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free, and only provide funding to treatment and support organisations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants* (HOR 2007:xxiii);

that Government reviews needle exchange programs to assess if they are *'successful in directing drug users to appropriate treatment which enables them to be drug free individuals'* (HOR 2007:xxiv); and that

> *Government provide funding only to organisations that adhere to the policy not to use language that glamorises or promotes the use of drugs, such as the terms 'recreational' and 'party' to describe drugs or drug use in public statements, correspondence and reports and that have implemented this policy to documents available electronically via their website. The Commonwealth Government also withdraw funding from organisations that promote legalisation of all or any illicit drugs* (HOR 2007:xxv).

These are just some of the recommendations in the report that demonstrate a rise in the zero tolerance discourse of drugs that have served to undermine the role of people who use illicit drugs in partnerships.

5.15 Conclusion – Analysing Policy Using a Governmentality Approach

In this chapter I have drawn upon Critical Discourse Analysis and Foucauldian inspired analysis to examine a number of government policy documents relating to illicit drug use. Using this 'historicising' approach I have identified how the use of language, the knowledge systems mobilised and the power relations between various stakeholders have impacted on policy development processes. I have also discussed how a governmentality framework of analysis can be a useful tool for understanding neoliberal responses to drug use, albeit with some limitations given the continued emphasis on law enforcement approaches, and the lack of evidence supporting the effectiveness of such approaches. I have identified in these documents the beginning of the concept of involving people who use illicit drugs in partnerships and argued that in the drug policy sector this has largely been a rhetorical tool aimed at conveying a sense of inclusion, particularly in comparison to partnerships in the HIV/AIDS sector. In the analysis of these documents I have also identified 'ruptures' and shown how the role of people who use illicit drugs in partnerships had become increasingly tenuous during the Howard Government's time in power as a result of the undermining of harm minimisation and an increased emphasis on a zero tolerance approach. This reflects a form of 'authoritarian liberalism' (Dean 2002; Hindess 2001; Valverde 1996) as opposed to an 'ideal governmentality' approach to rule

discussed in previous chapters, and limits the potential of rational approaches to reduce drug related harms. In the next two chapters I discuss the findings from interviews that were conducted with members of these 'partnerships'. These interviews focused on the concept of partnerships and further support my argument that the concept of partnerships involving people who use illicit drugs is largely a rhetorical tool employed by neoliberal governments to convey a sense of inclusiveness in the policy development process.

Chapter 6 - The Effectiveness Of Partnerships Involving Users

6.1 Introduction

This chapter analyses the positive and negative perceptions of partnerships involving people who use illicit drugs, as well as what I have labelled the 'barriers' and 'enablers' to effective partnerships involving people who use illicit drugs. In this chapter I also discuss issues that were identified as of special significance to Tasmania which facilitate an understanding of the failure to develop a sustainable peer-based organisation in the State. The key enablers of successful partnerships include: adequate resourcing and institutional support; recognition that people who use illicit drugs possess a specific expertise; and support from law enforcement agencies. The main barriers to successful partnerships include: lack of adequate resourcing; lack of an enabling environment; and negative attitudes of service providers. These barriers result from conservative, morally charged views of drug users and reflect to the concept of 'authoritarian liberalism' I discussed in Chapter Two. The enablers, on the other hand, reflected instances where an 'ideal governmentality' model, as discussed in the opening chapter, had been evident in practice.

This chapter is the first of two discussing the findings from interviews with 15 key informants who are members of what Fitzgerald and Sewards (2002) refer to as Australia's 'drug policy community'. A detailed description of the interview process - including ethical issues, sampling strategy, interview format and the analytical process adopted - is contained in Chapter Four where the research methodology is discussed in detail. The data from the interviews conducted as part of the research have been analysed, coded and synthesised to form a descriptive narrative of the conversational partners perception of partnerships and their effectiveness in influencing policy and service delivery. Throughout the next two chapters I discuss how the responses of the conversational partners can be usefully analysed drawing on a governmentality theoretical framework relating to the concept of partnerships in the illicit drug field, as has been discussed in detail in Chapters Two and Three.

6.2 Positive views of partnerships

During the interviews several conversational partners identified successful examples of partnerships involving people who use illicit drugs. These successes can be located within an 'ideal governmentality' model of practice, where rational evidence-based approaches that recognise the specific expertise of users have been adopted in developing and implementing government programs aimed at reducing drug related harms. Across the three cohorts of conversational partners: service providers; policy makers; and user advocates, there were, however, some markedly differing opinions about how successful the involvement of people who use illicit drugs in policy development and service delivery planning had been. No clear pattern emerged that these divergent views were related to the conversational partners role in the 'policy community'. This supports the view that the illicit drug field is notable for the 'contested political terrain' (Rowe and Mendes 2004:6-7) in which it operates.

One of the conversational partners, a service provider who has also been involved in policy development at both a State and Federal level believed that

> The concept of partnerships has been very successful. At the State level drug users [in NSW] are generally getting a voice at the policy table, not as much as I would like but we have to look at this as a gradual process that will take place over a period of time. So we couldn't really function as well as we do now unless we worked in partnership with drug users.
>
> We should be very proud of the collaboration between health and drug users, and the collaboration between users and police too. When we had the huge numbers of drug overdose deaths in the 1990's, the drug users in South Australia and the health department and law enforcement all got together and worked out guidelines about when police should and shouldn't be called (Respondent 1).

This initiative was subsequently adopted by most other States which developed similar guidelines aimed at reducing overdose related deaths (Wodak 2005:37). The rationale of such initiatives was that by addressing a fear among users that if they

were present at an overdose and police attended they would be charged for drug related offences. Most police personnel recognised that little would be achieved by pursuing criminal charges relating to drug use and the most important thing was to get urgent medical attention from ambulance officers in an effort to save lives. Other approaches that adopt such 'novel enforcement practices … complement public health efforts … [and are] more cost effective and less harmful than [conventional] drug market enforcement' (Kerr et al. 2005:216). This is indicative of an 'actuarial' approach to illicit drug use, as discussed in Chapter Two, whereby governments seek to weigh up the costs and benefits of choosing a particular course of action and demonstrates the utility of a governmentality theoretical framework in the analysis of current approaches to illicit drug use.

Other service providers, who also play a major role in policy development in their State, also felt that the involvement of users had been successful

> In some respects Australia has led the way in working in partnership with people who use illicit drugs. Through the NCADA and now the National Drug Strategy, the fact that, for example, we have funded user groups has been a critical part of our success in limiting the spread of HIV among injecting drug users and beyond to the general community. Engaging people who are users, or ex-users, people like Annie Madden [AIVL Manager] for example, have led the charge and been very influential in what you might call a healthy public policy.
>
> I've worked in many different countries where this has not been the case and it's good fortune that we have taken a different approach. And I feel the involvement of affected communities has been an important factor. The good thing is developing the linkages between the organisations and the medicos so they can run questions past you and get some proper professional advice and that can build capacity and sustainability. And for me that sort of thing is welcome because you can have an impact at a public health level as well as at an individual level (Respondent 3).

> To me the involvement of user groups was a critical part in the overall effectiveness of our response to HIV. If you took out the user groups all the other things such as needle exchange, peer education and methadone would not have been nearly as effective. So I think their contribution was massive (Respondent 4).

From the perspective of members of user advocacy organisations there were also positive views of the role of illicit drug users in policy development and service delivery

> The involvement of users in partnerships has been very successful. The user group in this state has involved users in setting up the service, developing the services policies and practices, and also service delivery. Just having their involvement, because it was a service for illicit drug users, having their input means that it specifically meets the client's needs.

> We had a really good project with Divisions of General Practice where we did opportunistic Hep A and B vaccinations as people came in. That was really successful. Because that idea came from the users, and we as a user group drew up a plan, then asked the Division of General Practice to be involved and send us a couple of nurses and a doctor. That was a really good partnership. And one of the nurses involved did a presentation talking about how great we were and how professional we were (Respondent 5).

The comments by conversational partners discussed in this section indicate that there have been several instances where the involvement of people who use illicit drugs in partnerships has been considered successful. These views came from across the spectrum of conversational partners, including user advocates, suggesting that there has been some real progress made in involving users in a meaningful way to achieve better policy and service delivery outcomes. It became apparent during the conversations that the informal networks developed by some service providers and policy makers with users were considered extremely valuable. However, it also

became evident that members of the 'drug policy community' feel more effort needs to be made in involving users in formal policy making and service delivery planning bodies to better utilise the 'specific expertise as well as experiential perspectives' (Fraser and Valentine 2008:127) they can offer in developing effective responses to reducing drug related harms. In the following section I discuss the views expressed by conversational partners who felt that the involvement of people who use illicit drugs in partnerships had not been as successful as it could have been.

6.3 Negative Views of Partnerships

In this section I discuss some of the negative perceptions expressed about the involvement of people who use illicit drugs in partnerships. The opinions expressed in the conversations reflect mixed views among members of Australia's 'drug policy community' of the success, or otherwise, of the role of illicit drug users in partnerships. As was discussed in the previous section, no clear patterns emerged from the data to indicate that different perspectives on the negative views of partnerships were related to their role as policy makers, service providers or user advocates. These negative perceptions of partnerships demonstrate that where an ideal governmentality model has not been applied it can undermine attempts to 'govern at a distance' through the unique expertise of people who use illicit drugs. This approach is more in line with the concept of 'authoritarian liberalism' discussed in Chapter Two where distinctions are made between those capable of bearing the responsibilities of freedom and those who are considered in need of more 'pastoral guidance'.

Charteris-Black (2005) has identified how politicians commonly employ rhetoric for a variety of ends in policy communication and the creation of myths and illusions. One user advocate felt very strongly that the concept of involving users in partnerships had been little more than a rhetorical device of government that reflects this view

> At best I would say that the involvement of users in partnerships is rhetoric and tokenism. After the NSW Drug Summit there was a recommendation about accreditation of methadone clinics and one of the standards that was put into the accreditation was about consumer

> participation in this process. I don't know any users who have been involved in the accreditation processes of these methadone services. And from our organisation's perspective we have never been surveyed or remotely involved in anything resembling consumer participation.
>
> And at a State government level we [users] are excluded from the main policy decision-making bodies. It has been discussed that we become members of these bodies but it has been decided that the peak NGO service provider body will be, but we as a representative of users are viewed as too much of an interest group to be involved at that level. We have a smattering of senior bureaucrats and the like but the people most affected, the drug users, are left out (Respondent 6).

This issue of service providers purporting to be able to represent the interests of people who use illicit drugs was another recurring theme in the interviews and are discussed in more detail in the following chapter.

Another advocate who had been involved in various incarnations of the now defunct Tasmanian user organisations had a similar negative view about the role of people who use illicit drugs in partnerships

> You look at what's happening in Tasmania now and still we don't have a lot of input or involvement of users. They remain a minority, that is very much an underground minority, and hence we still have huge issues around the transmission of blood borne viruses and other health issues. I don't think any of those have gone away, in fact they may have gotten worse (Respondent 7).

A service provider who has worked in the alcohol and drug sector for many years in Tasmania, and participated in a range of government policy development bodies over that time, also felt that the involvement of illicit drug users in partnerships had been a failure which has led to poor policy outcomes

> In Tasmania it has been totally unsuccessful. Really there hasn't been any such partnership that I know of in the last 15 years. There's no

> connection between bureaucrats and illicit drug users, there's no understanding at all, so I don't think they can produce a workable policy document (Respondent 13).

While the comments from conversational partners above suggest that the involvement of people who use illicit drugs in partnerships has not been successful, others felt that this approach had mixed success. One respondent working in the policy development area had conflicting views on the involvement of users in partnerships

> I would say to date involvement of users has been sporadic. It all depends on which perspective you take. In my experience of the drug treatment services system, not particularly successful. However, with some of the primary health services in Victoria I have had some external involvement with, their processes were more informed by the views of people who use illicit drugs. Consumers have some input into the day-to-day operations of these services. They seemed to have good processes in place, that I think came initially from the employment of peers, that allowed some of the potential cultural barriers, a sort of "us and them" divide, to be removed. There was a sense of a right to be in that space, there was a certain level of comfort which I have not necessarily seen in drug treatment agencies in Tasmania (Respondent 2).

One service provider, who also provided high-level policy advice to governments at both State and Federal levels, felt that Australia had failed to learn from previous experience of involving users in responding to critical public health issues

> In responding to HIV and HCV the effectiveness of partnerships with people who use drugs in Australia has been profound. But if you come to the area of drug treatment I think it's a very different story (Respondent 4).

It was felt by some conversational partners that this failure to learn from the successful response to HIV involving affected communities saw the stigmatisation of drug users persist in health services and other settings. Further, the Howard Coalition Government's "Tough on Drugs" rhetoric was felt to have placed harm reduction

technologies such as needle and syringe programs (NSP's), a hallmark of the successful response to HIV, at risk (Ballard 2005:22; Treloar et al. 2006). However, the Howard Government's increased funding support to expand needle and syringe programs indicates recognition of the important role they play in reducing drug related harm, even though the "Tough on Drugs" rhetoric has been argued to work 'against the involvement of affected communities in strategic and service delivery responses' (Treloar et al. 2006:3). These contradictions again support the view that the field of illicit drugs is a 'contested political terrain' (Rowe and Mendes 2004:6-7).

In this section I have discussed the views of conversational partners who felt that the involvement of people who use illicit drugs in partnerships has been unsuccessful or, as one put it 'sporadic'. As with the views that efforts to engage users had been successful that I discussed earlier, there was no clear pattern to suggest that a conversational partner's role in the 'drug policy community' influenced their perceptions on this. Again this highlights the contentious nature of partnerships involving users. In the following section I discuss some of the views expressed during the conversations about factors that impact on the meaningful participation of people who use illicit drugs in partnerships.

6.4 Enablers of Successful of Partnerships

During the discussions with conversational partners about the involvement of people who use illicit drugs in partnerships a number of issues were raised that they felt were key factors that facilitated or impeded successful partnerships. When analysing the conversations these were coded as 'enablers' or 'barriers'. In this section I discuss factors that were identified by conversational partners as 'enablers' of successful involvement of people who use illicit drugs in partnerships. There were several recurring themes which arose in the conversations including: the expertise that illicit drug users offered in relation to reducing drug related harms; the importance of institutional support and adequate resourcing, both financially as well as other types of resourcing; and the support of law enforcement agencies.

6.4.1 Recognising the Expertise of People Who Use Illicit Drugs

Recognition of the expertise of illicit drug users was considered a key indicator of the success of working in partnerships and was another recurring theme in the interviews. As discussed in Chapter Two, a defining feature of governmentality under neoliberal regimes is the strategy of deploying a range of experts to facilitate the 'conduct of conduct' and enable 'governing at a distance' consistent with neoliberal principles (Foucault 1994a; Rose 1993). As has been mentioned previously, the expertise of users also has a proximity to Foucault's notion of the 'specific intellectual' (Foucault 1994c). Fraser and Valentine argue that in recognition of their 'specific expertise as well as experiential perspectives … specific resources should be dedicated to ensuring their active involvement' (2008:127).

Service providers and policy makers recognised that people who use drugs have a unique expertise that they don't have, situating them in an ideal position to make significant contributions to government efforts to reduce drug related harms

> It's been terribly important to have drug users involved in drug education. They look at the materials that the advertising agencies produce [on behalf of State health departments] and they laugh and say we haven't used those terms since the 70's. If you put that poster up drug users will laugh at just how naive you are. And also [users] advise on things such as the best placement of such posters (Respondent 1).

> I think their existence was important, just in terms of the message it sent. The opportunities it created, their involvement on consultative advisory bodies and planning committees at every level, was important because of the rational and realistic perspectives they brought to the situations. The best education materials came out of the user groups without a doubt, such as the *'Handy Hints'* booklet. You lose perspective but at the time the *'Handy Hints'* booklet was revolutionary in its impact and it's

> probably fairly tame now. But there was nothing like it at the time and even the idea of it was revolutionary (Respondent 4).

Members of user advocacy organisations also argued that the specific expertise of illicit drug users brought a specialised form of knowledge, or in Foucault's terms *savoirs* (Turner 1997), facilitating the development of more effective responses to reducing drug related harm that only members of affected communities could provide

> You have that unique perspective that you're not going to get from others. You have a lot of other people wanting to have input, like government and other agencies, but they can only give a service delivery view (Respondent 5).

> These organisations have a greater level of credibility among users, a greater sense of trust and understanding of their issues. They can be open and frank with us and don't have to sugar-coat things (Respondent 6).

> You've got a window of opportunity, especially in Tasmania, because you have consumers who are intelligent and they have observed things and they really want to facilitate change. And if government isn't quick to pick those people up they'll either burn out or move onto other parts of their life and you'll lose all that expertise in the process (Respondent 14).

One user advocate encapsulates the concept of the desirability to 'govern at a distance' through 'expert bodies' in the following passage

> In terms of partnerships I think in regard to HIV it was quite successful. Government was keen to develop partnerships with the community, key figures within government fostered partnerships with community organisations to act as links between affected communities. And since the AIDS crisis has seen to have passed we still have some people in government, particularly in the area of HCV, that keep the notion of

> partnership with the community alive. But really they are interested in partnerships with peak organisations like ours rather than the wider community (Respondent 9).

Another example provided by a policy maker that the specific expertise of illicit drug users has been critical to the success of reducing drug related harms is the Pharmacotherapies Advocacy and Mediation Service (PAMS) operated by the Victorian user advocacy group, Harm Reduction Victoria (previously known as VIVAIDS)

> In terms of specific cases where people who use illicit drugs have been successful in developing effective policy or in service delivery planning I would have to say the PAMS service that VIVAIDS run is a good example (Respondent 2).

Recognition of the specific expertise of people who use illicit drugs was considered by some conversational partners as an indicator of the success of working in partnerships. This recognition was also considered an important 'enabler' for effectively involving them in meaningful partnerships. One service provider described their experience of supporting consumer involvement on the steering committee of a primary health care service for people who use illicit drugs

> One of the things that was recognised by the steering committee was that these were people with expertise, the same as the police were there for their expertise. So we actually paid them to attend any meetings they came to, as we arrange for any of our clients to get payment for participating in any research. If they're here at a meeting it's taking time away from what they are trying to achieve – scoring, using, travelling to the meetings and whatever else (Respondent 11).

A consumer advocate also felt that the recognition of the specific expertise of people who use illicit drugs was critical to the success of strategies aimed at reducing drug related harm and involving them in service delivery had a number of benefits

> They've been involved in education and information sessions that people are actually interested in and want to come along to. So one of the key factors was that the stuff was coming from the users, what they wanted to know and learn. And they could also see that their involvement was actually resulting in something, so they were getting some sense of ownership over the process. They were feeling part of it. Rather than being passive observers they were active and valued participants (Respondent 5).

In this section I have discussed some of the comments made by conversational partners that related to the unique expertise possessed by people who use illicit drugs that served as an 'enabler' to effectively engaging them in partnerships. As previously mentioned, this reflects Foucault's view of the 'specific intellectual' – 'the person who uses his knowledge, his competence, and his relation to truth in the field of political struggles' (Foucault 1994c:128). Hinton's research found that 'the term 'experts by experience' is gaining recognition as it claims specialist knowledge and a relationship of equals which narrows the gap between providers and users' (2010:13). Governments increasingly rely on such *savoirs* in policy development and service delivery planning processes and this has seen an increase in the involvement of consumers across a broad range of health issues. In the field of illicit drugs, however, it still has some way to go before an 'ideal governmentality' model is realised.

6.4.2 The Importance of Adequate Resourcing and Institutional Support

Another key factor attributed to the success of involving illicit drug users in partnerships was institutional support and the willingness of governments to provide adequate funding to facilitate the operations of advocacy organisations such as NUAA [The NSW Users AIDS Advocacy Organisation] and VIVAIDS (Wodak 2005:37). On the other hand a lack of adequate funding for such organisations was considered by Rowe (2004b:120) as restricting their capacity to engage meaningfully in policy development.

Some service providers felt that the provision of institutional support for user organisations demonstrated a strong commitment from government to the concept of partnerships and was recognition of the important role they play in reducing drug related harm, enabling 'governing at a distance' consistent with neoliberal governmentality approaches to rule

> It's encouraging that when NUAA was going through a difficult time that the NSW government was not prepared to see it fail and they put in, at their own expense, a coordinator to run NUAA. The drug users thought this was the ultimate betrayal and I tried to persuade them to think of it as the exact opposite - that this was the ultimate accolade! This was showing that NSW Health realised just how important it was to have a user voice which was a truly working partnership (Respondent 1).

> NUAA was probably set up more by professionals than drug users. VIVAIDS was, I think, much more of a grass roots movement and one or two of the people who had been involved in the old user's union were at least peripherally involved in setting up VIVAIDS. But I know that the Commonwealth was actively involved in setting up these users groups, and fund them and involve them, when there was very little evidence about their effectiveness (Respondent 4).

Again, this illustrates the utility of a governmentality framework for the analysis of partnerships in drug policy and service delivery processes. It is indicative of a desire to 'govern at a distance' and facilitate the management of reducing drug related harm through 'experts' as has been discussed above (Foucault 1994a; Rose 1993; Turner 1997) – in this case illicit drug users. This view was, however, not held universally with some user group representatives, as well as other conversational partners, arguing that more resources were needed to support user groups in their work. This is discussed in more detail later in this chapter in the section that looks at 'barriers' to effective partnerships.

Many service provision organisations in other health areas have formalised mechanisms for consumer involvement in policy development and service delivery planning. One example in Tasmania is General Practice South which has a 'Health Consumer Network' which, it is claimed, enables the organisation to have *'productive dialogue with consumer and community organisations on quality care issues'* (GPS 2009). Consumer representatives are remunerated for their participation *'and actively participate in Board meetings, training and all other activities undertaken by the Board'* (GPS 2009). The idea of adequately resourcing consumers to participate meaningfully in the illicit drug field, however, has not been widely taken up and this is discussed later in this chapter where 'barriers' to successful partnerships, as identified by the conversational partners, are discussed in more detail.

6.4.3 Other Resourcing Issues

While the excerpts from conversations discussed above highlight the view that adequate funding levels are critical to the effectiveness of engaging people who use illicit drugs in partnerships, a number of issues relating to institutional support were raised in the conversations. One user advocate discussed a positive experience they had when working in a group responsible for developing one of the many National Strategies relating to illicit drug use. This conversational partner felt that the mentoring and support of more experienced members of that writing group was invaluable

> Some of the people on the writing group, one or two had been involved in writing other strategies, so they were very proficient at what they were doing. So I felt they were supporting me and teaching me, which made it a good learning experience for me. And that's something I think we need more of, that sort of mentoring (Respondent 10).

This conversational partner felt that such mentoring and institutional support was a critical factor in the professional development of people who use illicit drugs but needed to be more widely implemented across the sector

> I was with one user organisation that used to bring in users as volunteers and then move them through the organisation so they could learn. I think we don't do enough of that, we need to mentor users more so they can learn (Respondent 10).

Another consumer advocate described how the user organisation they were involved with provided support for consumers to participate in service delivery planning

> The user group here would send a staff member along with a consumer to a State Methadone Committee meeting. They would meet with them beforehand and go through the agenda and talk about what was going to come up and then sit next to them at the meeting then talk about it with them afterwards. It was a good way to do it because then people weren't as scared or intimidated, because it can be quite scary to walk into this room and there's all these people there in suits (Respondent 5).

Another conversational partner, a service provider, felt that the provision of mentoring and support for people who use illicit drugs, as well as providing an enabling environment for them to participate in policy and service delivery development, was another critical factor if partnerships were to be effective

> If it's about inviting consumers to sit on a working group or steering committee about how to improve service delivery at an organisational level, making sure there's not just one person but at least two so people have peer support. That they have a worker or support person to assist them in understanding such processes, not necessarily someone on that group. And things such as having a consumer representative on the management committee of services to have a say in the governance and decisions about services that organisations make (Respondent 2).

In these last two sections I have described some of the resourcing and institutional support issues that were felt by conversational partners as critical factors in successfully engaging people who use illicit drugs in partnerships in a meaningful way. These findings fit with Hinton's argument that 'consumer involvement requires nurturing by government' (2010:10). Again there was no clear pattern to suggest that

a person's role in the 'drug policy community' was a significant factor in influencing their views on this matter, rather these views were shared by policy makers, service providers and user advocates. None of the conversational partners expressed views that suggested that resourcing was not a key factor in determining the success of involving users in partnerships, leading to the conclusion that this is one of the most important factors to consider when looking at developing meaningful and sustainable partnerships.

6.4.4 Other Enablers

One final enabler to effective partnerships emerged from the interviews relating to the involvement of law enforcement agencies in partnerships aimed at reducing drug related harm. While the partnership between users and law enforcement agencies can often be problematic, a point that is discussed in more detail in the following chapter, one conversational partner working in the area of drug policy felt that police had an important role in this area, in particular with harm reduction programs such as needle exchange

> Some people were shocked that the police were acknowledging the benefits of the program, others were saying you should be locking these people up. At the end of the day our intervention did have some impact in terms of ameliorating the opposition that existed at the time (Respondent 8).

This supports the findings of research that has shown by adopting alternative approaches to traditional law enforcement, police can complement the efforts of public health officials in reducing drug related harm (Kerr et al. 2005). This also supports the point I made above about the importance of institutional support as a key ingredient for the success of partnerships involving people who use illicit drugs. In addition it demonstrates that where agencies that have significant power in partnerships recognise the contribution they can make to reducing drug related harm in the community - and law enforcement agencies were identified by several conversational partners as having significantly more power than other 'partners' -

their contributions can make a difference to the health outcomes of affected communities. The issue of power relations in partnerships is discussed in more detail in the following chapter, as it was another recurring theme in the conversations.

6.5 Barriers to Successful Partnerships

In the following section I discuss some of the views expressed by conversational partners that I have identified as 'barriers' to successful partnerships. These barriers include: lack of resourcing; lack of an enabling environment; and the negative attitudes of service providers. In many instances these barriers mirror the factors identified as enablers in the previous section.

6.5.1 Inadequate Resourcing and Lack of Institutional Support

As discussed in the previous section, support through adequate funding levels, as well as other forms of institutional support such as mentoring and professional development, were considered a significant factor in the successful involvement of illicit drug users in partnerships, as well as an indicator of the success of a partnership approach. As with the whole notion of partnerships, however, all conversational partners did not share this view and several felt that inadequate resourcing was a significant impediment to effectively engaging people who use illicit drugs in partnerships. Members of user organisations expressed particularly strong views about this issue

> One of the biggest barriers to users participating fully in partnerships is a reluctance by government to resource users to participate. They generally hold meetings in business hours so if someone has a job and don't have the capacity to take time off to attend, and if their employer doesn't know they are on methadone this can be a real problem. Also basic things like travel expenses can be a barrier. So really the most effective way to overcome these issues is better resourcing to enable peer based services to broaden their coverage.

> And if you want to engage this client group it takes time, and it takes time to consult. So if you get a State policy document to comment on, you usually have a four week turnaround period, and there's no way we can unpack the document and consult with people in a meaningful way in order to provide meaningful feedback. If an organisation such as ours is supposed to be able to represent the issues of people who use drugs we need to be able to get around to speak to users, sometimes to small and isolated parts of the state, and we don't have the resources to do this (Respondent 6).

One conversational partner who had been involved in some of the now defunct user advocacy groups in Tasmania felt that a lack of institutional support was a significant barrier. Through their involvement with such groups in other States, as well as at a national level, they had developed a good understanding of factors contributing to the effectiveness of established organisations in other States

> So when you got back to Tasmania it made you really aware of just how little we were involved. Also, I think it created a false hope in that a lot of the groups on the mainland were funded and supported by government. They were invited into conversation and their input was eagerly sought and valued and respected. Whereas in Tasmania my feeling is that user groups were to be avoided, or thwarted basically. In the past users have organised themselves and said they want to be involved and I can't see why that can't be fostered in this state, as it is in most other states in Australia. But there's been money put into that, which is a problem here. We don't actually fund users to represent themselves or to be involved as has happened elsewhere (Respondent 7).

Another conversational partner who had also been involved in user advocacy organisations felt that a lack of commitment by way of institutional support from government was a serious impediment to developing sustainable partnerships involving people who use illicit drugs

> Down here in Tasmania we had to work really hard to get representation, and to get on government committees and stuff. It was a lot about building strategic alliances. I'm not sure what impact our input had in the long run because there was no paid work available for this so it wasn't sustainable in the long run. I don't think the various committees were conscious of the fact that they were asking for stuff that wasn't resourced (Respondent 14).

One policy maker felt that institutional support of user organisations was essential if users were to play a meaningful role in partnerships

> It comes down to political will and the State Government recognising through funding from various grants programs that there are some benefits for them, and for all of society, to have the views of people who use illicit drugs involved in the policy making process. This would show a commitment from government that they are interested in the issues people have (Respondent 2).

User advocates saw being excluded from the various expert advisory bodies that operate in several States as another significant barrier to meaningful participation in partnerships and further evidence of the importance of institutional support that extended beyond adequate funding levels

> We don't get a seat on the various expert advisory bodies. They are more for public consumption. I think it's at that level that they strategically work out how to keep doing the minimal amount of harm minimisation stuff they do while allowing the Premier to be seen to be tough on drugs. I think it's about managing that sort of stuff at that level. We are continually working on getting a seat on these bodies though. And that's a thing of distress for us because it disenfranchises the people we represent. We don't want seats on these things for our own glory, but we are the only symbol there is for the active participation of drug users into policy and strategies. There isn't any other mechanism (Respondent 9).

Where a seat at the table of various policy forums was offered, the lack of experience of working in such forums among users, as discussed earlier, was also considered a barrier to meaningful participation

> A lot of people in affected communities don't have experience at sitting on committees and don't understand the processes and how things work. And they might feel intimidated sitting in a room with all these people with big official titles and using all this language and acronyms that mightn't be understood. And I think sometimes some groups do it deliberately to try and exclude people. They try and race through things and speak really quickly and speak in acronyms and use all sorts of technical language.
>
> So we need to skill people up and mentor them and support them at meetings and things. And some people can be really quite open in their discriminatory attitude and quite condescending and dismissive. If people speak up they just shake their heads and that sort of thing. So skilling up and support are critical. I think a lot of drug users may already feel less worthy and not have a lot of confidence to attend these things (Respondent 5).

This view of the need to 'skill-up' people who identify as illicit drug users in order for them to fully participate in such 'expert bodies' was identified as a key barrier to effective partnerships by one conversational partner who had been involved with user advocacy groups in Tasmania

> There's been no process of skilling people up down here - we skilled ourselves up. And we've had to give our time and expertise for nothing. In some cases users are so disenfranchised that they just feel good about having the opportunity to participate. So it's like they get them at a discount rate. They come from a disempowered position so they feel grateful for anybody listening to what they have to say - and they don't make the demands that they probably would if they understood that their expertise is being gained for nothing (Respondent 14).

This supports the views expressed by conversational partners earlier in this chapter that one of the critical factors behind the successful involvement of illicit drug users in partnerships is adequately resourcing user advocacy organisations and this includes making provisions for professional development. Where this does not occur there is little chance of people who use illicit drugs being meaningfully engaged in partnerships.

6.5.2 Lack of an Enabling Environment

The issue of governments needing to provide an enabling environment in order for user groups to operate effectively was another recurring theme in the interviews. The World Health Organisation's *Ottawa Charter for Health Promotion* (WHO 1986) is a key guiding document for social policy making bodies in Australia and identifies the need for creating 'supportive environments' as a key to effective health promotion. The lack of an 'enabling environment' has been identified as a significant barrier to reducing drug related harm where the 'agency' of people who use illicit drugs is 'alternately facilitated and constrained by aspects of the wider environment, such as drug laws, poverty, social class and marginalization' (Moore and Dietze 2005:275). In the following section I discuss the views expressed by some conversational partners who felt that the lack of an enabling environment was another of the significant barriers faced in developing effective partnerships involving people who use illicit drugs.

Service providers identified a number of issues relating to the lack of an enabling environment that impacts on the effective involvement of illicit drug users in partnerships:

> A lot of the user groups go through a cycle, a flowering of effectiveness and then problems, but a lot of it has to do with the nature of the organisations. And it's partly to do with government relations with them which is always a bit back and forwards (Respondent 4).

> There's been reviews of all the bodies in other places, and there's been a range of problems which I think you always expect with that sort of group I suppose. To what degree do you build in checks and balances? These things can go off the rails, but so can any organisation. And what's that balance between giving it true autonomy? And like any organisation it often depends on personalities how well it functions (Respondent 3).

This is where comments made by one conversational partner regarding State Government support for NUAA, as discussed previously, highlights the need for adequate institutional support if user organisations are to remain viable and effectively represent their constituents in partnership arrangements. Conversational partners from the user advocacy cohort felt that a lack of leadership from governments on this issue was an impediment to effective partnerships

> For me one of the key barriers to successfully engaging users is the lack of leadership by government. They put in strategies that they will work with affected communities, but it's all lip service as far as I'm concerned. We need to see leadership, and I think the Commonwealth is better at it than State and Territory governments. I don't think we will see much at a local level, I think you knock on doors of State bodies and need to remind them that we actually have user groups there and they need to involve them if they are going to have effective services.
>
> There needs to be recognition, and they write in these documents that we need to work with affected communities, but you can only work with affected communities if they're skilled enough to do that. And maybe that's why they don't fund us as policy bodies or don't allow us to do advocacy work because they don't want to be told that what they are doing is not effective. Again this goes back to leadership from the State Government, if they stood up and said we need a drug user organisation, or at least a body that can represent their interests, we might move forward (Respondent 10).

This conversational partner felt the continued prohibition of certain drugs was an impediment to the creation of an enabling environment

> The criminality of drug use is a barrier that government hasn't moved on from. There's not an enabling environment and that's one of the things the strategies talk about, enabling environments. But you can't have that with the current laws or legislative environment that we currently have. Until that's looked at, and it won't be under the current government, nothing will change (Respondent 10).

The comments discussed in this section again indicate that the views of conversational partners were not influenced by their role in the 'drug policy community'. Across all three categories there was a view that more effort was needed in creating an environment that enabled people who use illicit drugs to participate meaningfully in policy and service delivery partnerships. As discussed at the beginning of this section, the *Ottawa Charter for Health Promotion* (WHO 1986) identifies this as a critical component in achieving better health outcomes. The views expressed by several of the conversational partners, as well as that noted in other research (Moore and Dietze 2005), suggests that this has not been the case in relation to substance use.

6.5.3 Attitudes of Service Providers

Another recurring theme raised in the conversations as a significant barrier to effective partnerships was the negative attitudes of many service providers towards people who use illicit drugs. In the following section I discuss some of the comments made during the conversations that indicate this has been another impediment to successfully engaging people who use illicit drugs in partnerships.

"Tough on Drugs", the National Illicit Drug Strategy launched by the Howard Coalition Government in 1997 identifies '*training and skills development for front line workers who come into contact with drug users or at risk groups'* (DOHA 1998) as one of the key priority areas in efforts to reduce drug related harms. Phillips and Bourne (2008) have also identified how the values of workers can impact on outcomes for consumers of drug treatment services. Hinton's research also found that service providers attitudes were a 'key determinant and require a long term process of

cultural change reinforced through awareness raising, training, supervision and mentoring' (Hinton 2010:10). A number of conversational partners, from across all three cohorts, expressed views that this had not been successful and that many workers in the sector continued to hold stereotypical views that people who use illicit drugs were somewhat dangerous and difficult to work with. This fits with the view of Ross and Darke that illicit drug users are often considered 'mad, bad and dangerous to know' (Ross and Darke 1992).

One service provider described their experience of working in a clinical setting and expressed concern that stigmatisation of clients was widespread in the drug treatment sector

> When I started at this organisation, I found that it was terrified of its own clients. It had policies that were defensive, almost paranoid, around the clientele that it dealt with. It had a whole range of explanations and constructions as to why we had these policies and philosophies. A lot of it was based on the self-fulfilling prophecy that our clients are dangerous, and of course if you treat our patients as dangerous they become dangerous.
>
> I had a senior psychologist here explain to me when I started about how dangerous our patients were. This person said our clients can look quite normal, they can act like normal, even for weeks at a time, but suddenly without warning they will turn on you. I thought it was more like a crocodile farm than a clinic!
>
> It's often about power and control and behavioural management of clients perceived to be dangerous. And with an organisational culture such as that it makes it difficult, or impossible, to work effectively with a drug user group. We are really primitive in our approach. There is a real fear of our clients (Respondent 4).

Several user advocates described their experience of the stigmatisation of illicit drug users by service providers, both in mainland States as well as in Tasmania

> One of the main barriers is that people are afraid to identify as users because of a fear of discrimination and because of the law. So prohibition and the discrimination that people are used to facing when accessing services, particularly from health services, when they identify as illicit drug users is a real problem (Respondent 5).

> There's a lot of ex-users employed in the drug and alcohol sector and I think it goes along with this NA [Narcotics Anonymous] philosophy around if you are using, ever, then you are really sick and anything you do is never any good (Respondent 14).

While several of the policy documents analysed in Chapter Five discuss the need for professional development of staff in the sector, conversational partners felt such entrenched values are difficult to change, particularly in a political climate where people who use illicit drugs are demonised and vilified. Several conversational partners considered that addressing this issue was critical if governments were to bring about meaningful change. Involving people from user organisations in training programs for staff of service delivery agencies was considered one means of bringing about such change. According to several of the conversational partners this is happening more frequently in some States, however, given Tasmania's lack of a funded peer-based organisation this has not been possible since the demise of The Tasmanian Users Health Support League (TUHSL).

While stigmatisation of people who use illicit drugs was considered one significant barrier to successfully engaging users in partnership arrangements, an issue that I discuss in more detail in the following chapter, some consumer advocates felt a fear of breaches of confidentiality was another key factor in limiting the effective involvement of consumers

> I think there is a perception that a lot of drug and alcohol services breach confidentiality. Particularly when they have a few components to their service like a needle exchange and a counselling service, and people go

> for court counselling. And I'm not sure if it is real or perceived but some people feel that their confidentiality is breached. I think that to help overcome this we need to have people really involved in the service delivery policies and planning and then people can have input into confidentiality policies and sharing information policies. And then they can actually see them at work. Being told that a service has a confidentiality policy and that staff are not breaching that is all well and good, but if you experience it in practice and are part of building that then maybe you will have more confidence in it (Respondent 5).

Not all conversational partners, however, felt that efforts to address the negative attitudes of service providers towards illicit drugs users had been unsuccessful. One user advocate discussed how the organisation they were involved in had made concerted efforts to overcome such discrimination on the part of service providers and had met with some success

> One of the things we found was there was a lot of discrimination from other services towards a user group, but one of the things we found over the years was that if we could manage to get them in through the door and work on something with them, like some joint partnership project, that they always left impressed and with their views totally changed. And they'd tell everyone how wonderful we were. So there was a lot of work to break down the stereotypes of users but it was really worthwhile (Respondent 5).

In this section I have highlighted the theme of service provider's negative attitudes that was raised by several conversational partners as a significant barrier to the meaningful involvement of users in partnerships. This theme, along with a lack of institutional support and adequate resourcing, and the lack of an enabling environment in which user groups could operate were considered key barriers to the success of partnerships. These themes reflect that traditional conservative morality continues to significantly influence drug policy and service delivery processes and represent a challenge to developing effective responses based on rational, evidence-based approaches to substance use as would be expected under an 'ideal

governmentality' model. It also highlights that a form of 'authoritarian rule' (Hindess 2001, 2005) continues to apply to those deemed not capable of bearing the responsibilities of freedom available to those deemed to have developed appropriate 'technologies of the self' (Dean 1999; Hindess 2001, 2005).

In the following section I discuss issues that were raised during the conversations relating specifically to Tasmania. These are important as they highlight some of the difficulties faced in establishing a sustainable user advocacy organisation in a State that has some unique characteristics and which has had a history of failed attempts at establishing such groups.

6.6 Tasmanian Issues

While some of the data from the conversations discussed above make reference to specific issues faced in Tasmania in establishing a viable user advocacy organisation, some of the conversational partners, both Tasmanian-based and from other States, identified a number of other key factors that impact on the establishment and sustainability of such an organisation in Tasmania. The following section discusses some of these Tasmanian specific issues in more detail.

One conversational partner felt that in Tasmania the involvement of people who use illicit drugs in 'expert bodies' was often little more than a tokenistic gesture on behalf of bureaucrats

> TUHSL [The Tasmanian Users Health Support League] had a seat on the NSP (Needle and Syringe Program) working party, but that was probably more as a result of strategic alliances we had built with individual people in government. But there was a lot of stonewalling at senior levels of the bureaucracy because they just saw consumers as sort of a throwaway issue. And it was as if they stonewalled for long enough that we would go away - and of course we did (Respondent 14).

Another conversational partner, who had worked for a number of years in service delivery and policy development roles, felt that in Tasmania there had been a culture

of denial among policy makers and service providers that there was a significant enough number of illicit drug users in the State for there to be any need to engage them in development and planning processes. Hinton's research also found there was a 'culture of denial about the extent of drug related harm' (2010:83) in Tasmania. This was seen as a significant barrier to the development of effective partnerships

> The biggest barrier that I ever saw was this view that there were so few drug users in Tasmania. They didn't even want to set up a methadone program because there were so few junkies. If we held out long enough those few junkies would eventually go to the mainland and Tasmania would be totally junky free.
>
> And what they were doing was minimising the estimates of the numbers of IV drug users. Then they tried a 'not in my backyard' approach – those users that were here must be from the mainland so if we don't offer services they will go back there. So there was a denial that people in Tasmania used drugs, and if they did they shouldn't be here, they should be on the mainland in someone else's backyard. This was back in about 1992 – and there was no consumer involvement at all (Respondent 13).

More recently, however, the Tasmanian Government's *'Alcohol, Tobacco and Other Drug Services Discussion Paper'* (DHHS 2007) recognised that the lack of a user advocacy organisation is an impediment to good service provision in Tasmania

> *Two other structural issues impede good service development for the sector. Firstly, there is limited involvement of non government services in policy and service development in Tasmania. Secondly, there is no consumer involvement in the policy development, planning and delivery of service provision in Tasmania. In fact, there is no consumer representative body for alcohol and drug services in Tasmania or even targeted advocacy services for people with alcohol and drug issues in Tasmania (DHHS 2007:34).*

The document states that one of the key strategic responses to this issue will be to *'Establish a model for consumer involvement in the policy development, planning and*

service delivery of alcohol, tobacco and other drug services in Tasmania' (DHHS 2007:35). Again this illustrates the desire of governments to 'govern at a distance' in policy development and service delivery, by utilising expert bodies, situated in a market where competitive tendering processes are a useful tool for regulating the 'conduct of conduct'. However, with no organised consumer body in Tasmania to respond to this issue the national body, AIVL, was the only organisation with the expertise and resources able to make a submission to this review (Madden 2010). The outcomes of this tender process will be discussed in more detail below.

Pharmacotherapy programs in Tasmania were considered by some conversational partners to have been relatively dysfunctional since the introduction of a methadone program in 1994. Consumers have had no formalised mechanism to raise concerns about their treatment, or their service providers, which is likely to impact on their health outcomes and reduce the effectiveness of this intervention. This has been recognised by the Tasmanian Government and was one of the issues looked at in the major review of services conducted in 2007 (DHHS 2007) and is a key focus of the *Future Service Directions* (DHHS 2008) paper released in late 2008.

As previously mentioned, some conversational partners felt that there had been very little effort made in Tasmania to involve people who use illicit drugs in policy development and service delivery planning. This was felt to be due to a lack of will on the part of senior bureaucrats to engage people who use illicit drugs in partnerships any meaningful way

> There was only ever a half-hearted gesture at the most for users to be at the table. It was very much a token thing. The only time I saw any real involvement at a reasonable level in the Health Department was at a meeting between the State and Commonwealth Health Departments where the Commonwealth were pushing for a group but senior State management were resisting it. Had the policy makers wanted involvement of users it could have been organised then (Respondent 13).

> I think it comes down to a lack of commitment from the State Government to fund an organisation. A lack of understanding about the usefulness of drug user organisations on the part of bureaucrats is another factor. Also some of the NGO's working in the sector need to commit to and support the development of a user group. It's bloody hard work to set up a user organisation. It's a resource intensive process just to get it off the ground and you need people that are skilled to enable that to happen and maintain it as a viable ongoing concern (Respondent 10).

A lack of institutional support for the establishment and maintenance of sustainable peer-based user organisations was discussed earlier in this chapter and identified as one of the major barriers to engaging people who use illicit drugs in partnerships in a meaningful way. While this is not unique to Tasmania, and conversational partners in States where such organisations existed felt that more resourcing was needed, the fact that no government funding whatsoever has been made available for such an organisation in Tasmania highlights the importance of this issue. However, several conversational partners felt that funding alone was not the only impediment and that there also needed to be a clear intent on the part of government to involve consumers in policy making and service delivery planning processes.

One conversational partner, who had worked in policy development and service delivery, felt that senior State bureaucrats in Tasmania had failed to make a serious commitment to involving illicit drug users in policy development partnerships

> At several senior meetings the question was asked about if there should be user representation at these meetings, but it was lip service, no real commitment that I ever saw. There's no real will on the part of policy makers to have any involvement of consumers (Respondent 13).

This conversational partner also felt that the attitude of workers in the treatment sector in Tasmania, as well as senior bureaucrats in the State, also posed problems for the development of effective partnerships involving people who use illicit drugs

> I think in Tasmania that too many people working in the treatment field have always had a moralistic bent. I think that's always been a primary factor in their involvement. And in the Health Department, right down from the top, they are very anti-drug user in every way (Respondent 13).

The negative attitudes of service providers were discussed earlier as one of the key barriers identified as an impediment to successful partnerships. And while some conversational partners in other States felt that there had been some improvement in this area in their own States, those from Tasmania, or with some experience working in the sector in the State, felt this continued to pose significant barriers in Tasmania

> I think service providers down here in Tasmania ignore drug users, I think they would rather work with their families. They'd rather spend time telling their families how to get rid of them and that will solve the problem. I really think services are frightened of their clients. I really believe they are frightened of drug users. Instead of employing people who are comfortable with drug users they just continue to employ middle-class people who don't have any experience at all relating to drug users. They might learn a little bit while they are on the job but they are much more comfortable talking to the families and that's not necessarily in the best interests of drug users (Respondent 14).

> Another problem is the reluctance to employ peers in organisations in Tasmania, some of the services I have seen there are not at all user friendly. Given what's going on down there, there's not enough information available to users to reduce harms. I went to one organisation and said we have a couple of people interested in doing some volunteer work. But the response was "they're on pharmacotherapies and you can't trust them". And I've seen this in other places where you have a conservative overseeing management body that doesn't want to employ peers (Respondent 10)'.

This view that service providers were suspicious, and in some cases even fearful, of their clients was echoed by another conversational partner who had been involved in previous user organisations in Tasmania as well as in other States

> I think that because Tasmania is isolated and has a different drug user profile to some other states that services down here see drug users as hostile, dysfunctional and problematic. Also, that you wouldn't want to engage with them at a personal level or as individuals and you wouldn't want to give them any voice in the organisation at all because it just wouldn't work (Respondent 14).

It was felt by one consumer advocate that the issue of ensuring confidentiality was particularly problematic in Tasmania because of its small size

> Anonymity and confidentiality can easily get lost in a small state like Tasmania. No matter what the best intentions are, sometimes it can be hard for people to guarantee that (Respondent 7).

Another conversational partner involved in service delivery and policy development also felt that Tasmania's small size was an impediment to engaging people who use illicit drugs in partnerships

> In Tasmania no one wants to put their head up over the parapet and say they are a user. If you look at the gay movement in Tasmania they were exceptional. To put your head above the parapet back then when homosexuality was illegal took incredible fortitude. But it's more difficult still for a more marginalised group like drug users to go public (Respondent 13)

This view supports the findings of ANCARD (1999) and Ballard (2005) discussed in Chapter Three relating to the response by the gay community to HIV/AIDS and how the stigma attached to illicit drug use made it more difficult for people who use illicit drugs to respond to drug related harms in an organised an effective manner. Gay law reform in Tasmania was achieved as a result of arguing from a human rights perspective. Hathaway (2002) argues that a key task in bringing about a truly liberal

approach to drug use is 'that of expounding a view of morality founded on tolerance and respect for autonomy as indispensible ends in themselves' (2002:401) based on a similar human rights framework. The concept of 'authoritarian liberalism' I have discussed elsewhere, however, is likely to be an impediment in this endeavour due to the fact that while neoliberal ideals characterises individuals as autonomous actors their choices and actions are only possible 'within circumscribed boundaries' (Zajdow 2004:75).

In contrast to the views expressed above, one conversational partner who had worked in user advocacy organisations in other States, did not share the view that the issues discussed above about the unique nature of Tasmania were such an impediment to an effective user advocacy organisation. Again the issue of institutional support was considered a key factor

> I'm not convinced Tasmania is all that unique. The Northern Territory has had a few organisations and they are smaller than Tasmania – there's no currently funded organisation there either. The dispersed population in Tasmania isn't a major factor either, just look at the success of the WA group [West Australia Service Users Association – WASUA].
>
> I think it comes down to a lack of commitment from the State government to fund an organisation. Also a lack of understanding about the usefulness of drug user organisations on the part of bureaucrats is another factor. Also some of the NGO's working in the sector need to commit to and support the development of a user group (Respondent 10).

This last comment suggests that establishing and maintaining a user advocacy organisation in Tasmania is likely to be a complex process that needs to consider all the factors identified by the various conversational partners discussed above.

In 2009 the State Government provided funding to Advocacy Tasmania, a non-peer based organisation, to represent the interests of people who use illicit drugs and are currently in some form of treatment. However, as negotiating access to treatment services is often a difficult process and as the majority of people who use illicit drugs

are not in treatment, or indeed seek or need treatment, this service can only represent the interests of a small group of 'problematic' substance users. AIVL and peer-based organisations in other States have expressed concerns about how such a service can effectively represent the interests of users given they are not peer-based and are not likely to be fully cognisant of the issues facing people who use illicit drugs (Brogan 2010; Madden 2010). However, as I discuss in the following chapter, this appears to have been a more politically palatable option for the Tasmanian Government. Based on the recommendations of the '*Future Service Directions'* (DHHS 2008) document, Government did not want to be seen to be doing nothing to involve consumers and this conveys the impression they are acting upon the recommendations of the report.

6.7 Summary – Partners Perceptions of Partnerships

In this chapter I discussed the findings from the interviews with conversational partners who expressed positive and negative perceptions of partnerships, as well as the enablers and barriers identified that need to be considered in facilitating the capacity of government to 'govern at a distance' through user advocacy organisations.

The key enablers identified were: the importance of institutional support and a recognition of the need to provide adequate resourcing, both financially and to foster development of the skills of consumers to enable user organisations to operate effectively; a willingness to recognise the expertise of illicit drug users in developing effective responses to drug related harms; and the support of law enforcement agencies. The key barriers were also related to resourcing issues, but also included the provision of an enabling environment in which such organisations could work effectively with their constituents. A further barrier identified in the conversations related to the negative attitudes of service providers towards their clientele. I also discussed issues that conversational partners felt were specific to the involvement of people who use illicit drugs in Tasmania.

When analysing the data no clear pattern emerged that the views held by the conversational partners were related to their role in the 'drug policy community'. It is evident that there are mixed views about how successful attempts to 'govern at a

distance' through partnerships with user advocacy organisations has been. It is also evident that while several of the conversational partners felt there have been some successes in reducing drug related harms though a partnership approach, there remain a significant number of barriers that need to be addressed in order for such an approach to be widely accepted by affected communities as being truly effective.

Chapter 7 – Other Issues Impacting on Partnerships With Users

7.1 Introduction

In this chapter I discuss a number of other key themes that emerged during the conversations that impact on the effective involvement in partnerships of people who use illicit drugs. The themes identified in this chapter are: the representation of users; the impact of prohibition; pharmacotherapies as a form of social control; a new moral conservatism that was evident in the drug policy arena; the political nature of evidence; power relations in partnerships; and the silencing of dissent when user advocates spoke out against government policy. The themes discussed build on those covered in the previous chapter in which I analysed positive and negative perceptions of the involvement of people who use illicit drugs in policy and service delivery development partnerships, as well as 'enablers' and 'barriers' to meaningful participation in partnerships.

While not all of the themes discussed in this chapter relate specifically to the role of illicit drug users in partnerships, they are still of relevance to Tasmania, where no user advocacy organisation currently exists, and provide evidence to be considered if a sustainable peer-based organisation is to be established in this State. As in the previous chapter I argue that key themes discussed by conversational partners can be situated within a theoretical framework of governmentality making it a useful tool for understanding the neoliberal project of partnerships. Many of these themes relate to discourse and knowledge/power that were key concepts in much of Foucault's work (Gordon 1994). These topics were identified as recurring themes during the analysis of the interview data and are discussed in detail below.

7.2 Representation of Users

The issue of representation of people who use illicit drugs, and who were best placed to represent their interests in the partnership process, was a key theme arising during the interviews. This is a key concern for governments seeking to 'govern at a distance' (Rose et al. 2006a) as it is critical for them to identify suitable individuals or

organisations to represent the interests of all users if this strategy is to be effective. The notion of governing at a distance was summed up by one conversational partner who felt that governments relied on user groups to perform a role they could not

> Whether we are seen as a legitimate voice or not, they see us as a way of doing things in a hands off way. We can deal with the drug users, we can provide them with advice, but they don't see themselves, in my opinion, as being in partnership with the drug user community (Respondent 9).

One conversational partner working in the area of policy development, however, expressed doubt about the legitimacy of who was best placed to represent the interests of illicit drug users

> I don't think it would be any easier if there was an identified user advocacy group [in Tasmania] to work with, because I don't think a user group necessarily speaks for all users. Users are such a broad range of people, their patterns of use are all different, their lifestyles are different, their employment status is different, how they access their drugs differs. Like how do you say that someone who uses a few ecstasy tablets has the same needs as someone injecting drugs that are meant to be taken orally, or people who are using methamphetamine? They are all breaking the law but all have different interests (Respondent 8).

Hinton's research also found this a problem as

> Organisations tend to represent one type of consumer with particular needs which are not necessarily shared by others. For instance, opiate injectors have different issues and concerns to those using cocaine, cannabis or dance drugs. Injecting drug users have in many respects led the user involvement movement both in the UK and in Australia and this has marginalised the voices of other drug users (Hinton 2010:14).

Other conversational partners held different views and recognised that the issue of identifying as an illicit drug user often made people reluctant to come forward and seek to advocate on behalf of other users

> Something I have heard from people involved in policy, and something I have challenged, is "who is the user to represent all users?" I guess there is some legitimacy to that but my response has been it's whoever puts their hand up and has support and structures and consultation mechanisms to get feedback from others so that it's not just an individual driving their own agenda (Respondent 2).

The provision of adequate support mechanisms was identified as a key issue in the previous chapter as well as in the chapter discussing the various policy documents in which the notion of 'capacity building' was listed as a key strategy for reducing drug related harms. In Tasmania, where no funded user organisation exists, the State Government has recognised this as a gap that impedes effective policy development and service delivery and made a commitment to supporting the establishment of such a body to address this (DHHS 2008). The organisation eventually chosen for this role through a formal tender process to advocate on behalf of users, however, has no peer representatives. This decision has raised concern among peer-based organisations in other States, as well as with the national organisation AIVL (Brogan 2010; Madden 2010).

There were divergent views on the issue of representativeness among conversational partners with one member of a user advocacy group believing that such organisations needed to have a greater capacity to employ a wider range of staff if they are to be considered truly representative

> A lot of the people that work in user organisations are middle-class junkies, not all, but a good percentage. And how can they adequately represent the interests of the wider population of users? They can't (Respondent 10).

Another conversational partner who worked with a user organisation expressed a similar view about the need for user organisations to be adequately resourced to enable them to include a wide range of people if they are to adequately represent the views of their peers

> You have your small vocal group and then others who just want to get on with things and not make a noise. So there is a question about how representative a user group really is (Respondent 5).

A service provider expressed the view that the diversity of people who use illicit drugs was a significant impediment to developing an effective user advocacy organisation in Tasmania

> I suppose the other thing is that drug users come from widely different backgrounds so that's likely to be a barrier. There's differences say between a Sandy Bay [an inner-Hobart, high SES suburb] junkie and your Clarendonvale [an outer-Hobart low SES suburb] junkies. It's a diverse group and it's difficult to get representation from such a diverse group. Your Sandy Bay users probably aren't interested in representation because they don't want to be known. They've got the money to buy the drugs, it's in the leafy suburbs behind closed doors. Whereas your Clarendonvale users are too busy chasing drugs, surviving really, because they're from the lower socioeconomic groups. It's not just about getting their drugs, its getting food and everything else. So the ones that could possibly represent users, the ones with the wherewithal as far as resources go, haven't got the interest. The other ones haven't got the time or capacity (Respondent 13).

Where users had been involved in the management committee of harm reduction services in a formalised way they were still subjected to criticism from their peers for not adequately representing the views of all users

> The users got a lot of flack from other clients. This was for things like they didn't represent the clients, only themselves. So even though we had nominations and an election it was still difficult in many ways. It was a difficult position for them to maintain, trying to please everyone all the time (Respondent 11).

As discussed in the previous chapter the issue of adequate resourcing of user organisations was identified as a key factor in their effectiveness. These

comments about the limited staffing capacity of these organisations are highlighted by the views expressed above.

Another issue identified in the interviews was that of service providers claiming to be able to adequately represent the views of their drug using clientele

> In recent years there's been a move away from having user groups on various committees in an advocacy role, now it seems that there is more focus on having service providers on these bodies. I don't think you can have a service provider on a body to represent users' views (Respondent 5).

A number of user advocates expressed concerns about service providers purporting to be able to represent the interests of users and felt that this was becoming increasingly common under the Howard Government's "Tough on Drugs" approach. This was seen as symptomatic of an increase in stigmatisation and marginalisation of users that some felt had occurred as the issue of illicit drugs became increasingly politicised under the Howard Government. It was also felt to be indicative of the power relations that existed in partnerships, with people who use illicit drugs considered to be the least powerful members of these partnerships, a theme I discuss in more detail later in this chapter. One of the key enablers of successful partnerships identified in the conversations, as discussed in the previous chapter, was recognition of the expertise of illicit drug users and the unique perspective they can bring to policy development processes. The decision by the Tasmanian Government to provide funding to a non-peer based organisation to represent the interests of users, as discussed previously, can be seen as a continuation of this trend. This decision also supports Fraser and Valentine's (2008) argument that neoliberal governmentality approaches to rule, in which users are considered not to have adopted appropriate 'technologies of the self', means a 'surrender to (and of) the powers of speech' (2008:45) which often sees them excluded from policy development and service delivery planning processes in spite of the specific expertise they can bring to partnerships if provided with an enabling environment. It is also consistent with Friedman's view that in a political climate of

prohibition the rights and capacity of users to be involved in decision making processes is stymied (1998:18). Smart's argument that

> such forms of knowledge have been steadily discredited, disqualified, or rendered illegitimate by the very institutions and effects of power associated with the prevailing 'regime of truth' within which the modern intellectual operates (1991:165)

is also helpful for understanding this. As a result, users roles in partnerships are considerably limited and the effectiveness of the contribution they can potentially make to partnerships aimed at reducing drug related harm is undermined. This theme of the impact of prohibitionist approaches to substance use is discussed in more detail in the following section.

7.3 The Politics Of Prohibition

The nature of Australia's neoliberal democratic political system, and the impact this has on contemporary approaches to illicit drug policy was felt by a number of conversational partners to be another significant factor impacting on partnerships with illicit drug users. As was discussed in Chapter Three many politicians are reluctant to challenge the dominant prohibitionist discourse on drugs for fear of alienating their electorate and losing power (Coomber 1998; Hartnoll 1998; Wodak and Moore 2002). This is complicated by the fact that the possible benefits of any significant change in drug policy are likely to be long-term while the political costs are not (Wodak and Moore 2002:9). It was also felt that the Howard Government's "Tough on Drugs" discourse had served to increasingly politicise the issue of illicit drug use (Macintosh 2006). One service provider felt that the nature of democratic political systems posed a significant challenge to engaging drug users in partnerships

> For me the political barriers preventing effective partnerships with drug users' comes down to the political utility of scapegoating and marginalisation. I believe it's not about the drug it's about the power relationships. Politics is not about developing and implementing policy

> that achieves agreed upon social goals, it's about balancing competing interests (Respondent 4).

Friedman (1998) argues that 'policies that maintain or increase drug-related harms may be less an "error" than a rational way to defend the interests of the powerful' (1998:15). This view was also shared by Levine who argues that governments find prohibition useful for their own purposes (Levine 2002, 2003). Friedman posits that, in order to maintain power, vested interests use a range of strategies to deflect attention from failed social policies by targeting vulnerable sections of the population. The quote from the conversational partner above suggests that a governmentality approach has some limitations, as I have discussed in Chapter Two, and that in order to more fully understand the rationalities and strategies adopted as part of the 'art of government' we also need to consider the theoretical concept of 'the political economy of drug user scapegoating' (Friedman 1998).

A conversational partner from a user advocacy organisation felt that political factors and the dominant discourse of prohibition had played a significant role in stymieing the involvement of drug users in partnerships and that this was largely due to the increased influence of conservative politics

> There used to be a user representative on the ANCD but they got kicked off because John Howard didn't want them on the group. User advocates sit on some of the sub-committees but they don't get a seat at the main table, which is another interesting shift I've noticed (Respondent 10).

Regarding the influence of a morally conservative prohibitionist discourse and the impact this has on the viability of a user group in Tasmania, one conversational partner felt that the nature of democratic political systems was significant

> In Tasmania there's a tendency for the more conservative politicians to have a lot of sway. And basically users and user groups are politically unpalatable and, I think, people don't want to be tainted with that. It's a fairly conservative State. There are vested interests. Certainly at the ballot box you don't want to risk that (Respondent 7).

A conversational partner involved in policy development also felt the conservative nature of the Tasmanian electorate, and the nature of the State's political system, were key factors in limiting the role of user groups in policy development and service delivery planning

> Just as Tasmania is divided on issues such as forestry and environmental issues it's also divided around the issue of drug use. The popular majority hold a view, which is not necessarily an informed one, while a number of others hold more progressive and informed views but never the twain shall meet. Politicians aren't going to risk upsetting the popular majority. So the nature of our democratic system does impact on these sort of things (Respondent 2).

The decision to fund a service provider organisation to represent the interests of people who use illicit drugs in Tasmania can be seen as evidence to support the views of conversational partners who considered that the dominant discourse of prohibition is a significant factor impacting on partnerships with people who use illicit drugs. Funding an established mainstream advocacy organisation, and one with no experience in the illicit drug sector, appears to have been a more politically palatable option that was less likely to court criticism from powerful interest groups and opposition parties than if the Government was seen to be supporting a peer-based user organisation. The comments made by the conversational partner immediately above support this notion of 'political palatability' as a factor in this decision. Although the decision to fund this organisation was made after the completion of the interviews, one conversational partner from a user advocacy organisation put a very succinct view of the impact of political factors on partnerships with user groups that supports my contention about 'political palatability'

> Governments are just shit scared about being seen to fund drug user organisations (Respondent 10).

The continued prohibition of certain substances had been noted in a review of the 3rd *National HIV/AIDS Strategy* conducted by ANCARD as an impediment to meaningful involvement of people who use illicit drugs

> The illicit nature of injecting drug use acts as a barrier to the establishment of peer networks; consideration should be given to law reform that would protect such networks from the threat of prosecution (ANCARD 1999:135).

Similarly Hinton notes that the 'tendency to scapegoat people who use drugs and alcohol is accentuated by the illicit nature of much drug use which can isolate and stigmatise' (2010:13), this makes the practice of partnerships with people who use illicit drugs particularly challenging. The marginalisation of illicit drug users that results from this prohibitionist discourse and structural impediments such as those discussed by the policy maker immediately below suggests that any strategy which seeks to involve people who use illicit drugs in partnerships almost untenable at this stage in Tasmania

> There's no doubt that the idea of community development and peer education are critical as we saw around the development of responses to HIV/AIDS which were so successful. Gay men's groups were able to respond collectively and had some economic leverage whereas marginalised groups like illicit drug users are less likely to do that because they are engaged in what are currently considered illegal activities. They are less likely to put their hand up and say "yes, I engage in these activities and I think we need to be doing things differently" for fear of retribution.
>
> Tasmania's small size impacts on this, particularly in regional and rural areas, as is the case in such areas across the country. People are less likely to disclose their health status on a range of different conditions as well as their particular behaviours, and drug use is one of those. Tasmania having one of the most regionally dispersed populations in the country also adds to this (Respondent 2).

The illicit nature of drug use was identified by ANCARD (1999:134) as a significant barrier to partnerships involving people who use illicit drugs as, unlike many in the gay community, they have limited access to those in positions of power. Ballard (2005:10) also noted the significant political leverage the gay community had in comparison to people who use illicit drugs that impacted on their role in partnerships and the comments of the respondent immediately above reflect this view.

Several policy makers suggested that the current climate of prohibition was a significant impediment to the effective involvement of people who use illicit drugs in partnerships. A conversational partner working in a policy capacity made the following observation

> Police have a difficult time coming to grips with user groups other than at a broad policy level within a harm minimisation framework. Police can see the value in not policing actively in and around NSP's because of the public health benefits. However, in terms of being able to sit down and work it through with drug users about what elements of the law police should enforce and not enforce, they would be in breach of their duty, which is first and foremost to enforce the law (Respondent 8).

User advocacy representatives also discussed how the dominant discourse of prohibition, and the marginalisation and stigmatisation of users that stemmed from this, was a barrier to effectively engaging users in meaningful partnerships

> Government's make this assumption that a drug user organisation will be problematic, even though we have this amazing track record, we've been able to do stuff and do it well and do things that others couldn't do. But there's still this great level of fear around us and that's probably political too. The stigma attached to illicit drug use is still very strong and this comes through in these partnerships (Respondent 10).

> Really the community is painted black by people. It's somewhere where the Premiers of the States are not interested in any shape or form of being

> associated with people who use illicit drugs, or saying or seeing that these people have anything positive to contribute. That has to be hidden. We are not allowed to talk about the notion that there are people who use illicit drugs in a functional way because that would be seen as encouraging drug use. This makes it very hard for us to do our job because the one thing we want to do is to help people to remain as functional as possible. Knowing they are not going to give up using drugs until they give up using drugs, if they do give up using drugs.
>
> And any notion of working constructively with drug users, recognising their rights as people, that they are still part of the social contract. You can make them poor victims who need our help and feel sorry for them, but at the same time they are nasty criminals and a danger to your family (Respondent 9).

Another conversational partner felt that the marginalisation and stigma attached to illicit drug use was further complicated by recent government focus on the concept of comorbidity, whereby a significant amount of government funding had been made available to organisations to deal with coexisting mental health and substance use issues

> One of the trendy buzzwords at the moment is comorbidity but that just creates further stigma for drug users and more misunderstanding about what their issues are. It's a way of saying we will stigmatise you even more if you continue to use drugs and it's a way of looking down their noses even more at people. It's more of the fear campaign about drug use and it disenfranchises people more. There's no recognition of functional drug use - it's like if you continue to use drugs you're mad (Respondent 14)

This increased focus on comorbidity is reflected in the Federal Government's funding of a range of programs under the National Comorbidity Initiative which was allocated $17.9 million over seven years from 2003-04 to 2009-10 (DOHA 2009). However, several conversational partners, like the one quoted above, felt this increased focus

was more about an inability to explain continued use of illicit drugs rather than being based on any real evidence of an increase in coexisting mental illness and substance use disorders. This is consistent with the pathologising of drug use and the absence of pleasure discourses relating to substance use discussed in Chapter Two. As one service provider put it

> The emphasis on comorbidity in recent years is in some ways an attempt to win the debate on mental health grounds and inflate the mental health risks of cannabis. It's an acknowledgement that the attempt to win the debate on physical health grounds failed (Respondent 1).

As discussed in the previous chapter, Tasmania's small size as well as the culture within its 'drug policy community' where, as in other States, the police play a significant role was also considered a significant barrier to engaging users in partnerships in any meaningful way

> In Tasmania, the local cops just don't get the idea of a user advocate. I was at one forum there and the cops just turned around and glared at me – it was actually quite intimidating in a way, even though I had a legitimate place and role at the forum. But the cops didn't seem to get it. And that's one of the main barriers in Tasmania in getting up a viable user organisation. The small size just makes it too difficult (Respondent 10).

Another conversational partner from Tasmania had a similar view of the 'policy community' and the nature of democratic politics in Tasmania

> At the higher levels of policy making the police do have a very high profile and have a great deal of influence. And it's made harder because of the nature of politics and the networks in Tasmania (Respondent 13).

This discourse of prohibition and the stigmatisation and marginalisation of illicit drug users was also perceived to pose problems for user advocacy organisations in terms of effectively reaching their constituency

> Some of the barriers to involving users include the fact that we don't know where they are, or who they are. The people who use drugs who are involved in employment, or study, or have a family - they have an investment in society and are trying to keep it together. The overwhelming majority aren't going to stick up their hands and say "I'm a drug user". Now some of them do and they will access services but we don't know how many of them there are, we can only make estimates.
>
> So that's the biggest problem is that it's a hidden population. And because of the stigma and discrimination, and the consequences of being outed as a drug user, most will choose to remain anonymous. So it's very hard to get to them, to find out what their needs are, what their experience is, to be able to feed that into the evidence base, and to be able to work with them to design interventions that are going to benefit them. You can't have a partnership with people if you don't meet them or you've got no means of communicating with them (Respondent 9).

The continuation of a prohibitionist approach to drug policy is not, however, supported across the board by politicians. Many politicians at both State and Federal levels belong to a group called Australian Parliamentary Group for Drug Law Reform. This is a cross-party forum that has members from all the major political parties. Even so the forum does not appear to have significant influence on the development of drug policy, however, their existence further highlights the contested nature of current approaches to illicit drugs. This also relates to Foucault's notion of power and discourse and what *savoirs* count as authoritative and are adopted as truths (Gordon 1994) as I discussed in Chapter Two. It also supports Foucault's view that 'resistance is an endemic fact in the world of power relations' (Gordon 1994:xx) as I also discussed in that chapter.

In this section I have discussed one of the most commonly recurring themes arising during the discussions with conversational partners. Service providers, policy makers and user advocates all felt that the 'politics of prohibition' and the resulting marginalisation of users, was a significant barrier to meaningful engagement of illicit

drug users in partnerships. Even the conversational partner working in law enforcement policy recognised this. The conversational partners highlighted that drug policy in Australia, and other similar democratic countries, is driven by a desire to maintain power rather than improving health outcomes for people who use illicit drugs. Steiner argues that 'politicians have a vital interest in appearing "tough on crime" and thus appeasing their constituents' (2001:188). Also, as Friedman (1998) has argued, the stigmatisation and scapegoating of drug users that results from this may be a strategic approach to defend the interests of powerful actors rather than a result of poor policy. This also supports Dean's (1998) contention that political logic, rather than a rational evidence based approach, continues to dominate neoliberal social policy. Similarly, Levine (2002, 2003) argues that governments find prohibition has a certain political utility. None of the conversational partners expressed any optimism that this situation would change in the short term. In fact many felt there was evidence to suggest things had become worse in recent years under the Howard Coalition Government as a result of its "Tough on Drugs" discourse. Wodak et al (2004) argued that the Disability Discrimination Amendment Bill tabled in 2003 by the Federal Government was indicative of the discrimination faced by people who use illicit drugs under the current prohibitionist approach. The proposal to permit legal discrimination against people who use illicit drugs unless they are in treatment again suggests the utility of a governmentality framework of analysis, with one of the key concerns of governmentality scholars being the 'conduct of conduct' as is discussed later in this chapter.

7.4 Pharmacotherapies as Social Control

Philippe Bourgois (2000), writing about methadone programs in the United States, used a Foucauldian framework of analysis to describe the dehumanising effects of such programs and how they equated to a form of social control. Pharmacotherapy technologies such as methadone maintenance are said to have as their main objective 'the governance of risk generated by drug dependency' (O'Malley 1999a:204). Fraser and Valentine (2008) describe how methadone is a technology used by neoliberal forms of government to 'make up' responsible citizens. In Chapter Three I described

this as constituting a 'pharmaceutical panopticon'. The notion of pharmacotherapies being used as a form of social control, or as a technology to shape 'the conduct of conduct' was raised by a number of conversational partners, although there were differing views on this among some service providers.

One service provider working in a drug treatment agency felt unequivocally that pharmacotherapies were a form of social control and that this impacted negatively on the potential of meaningful partnerships with user advocacy organisations in the planning and development of treatment services

> One of the main barriers to successfully engaging user groups is the defensiveness as to why we are working in this sector in the first place. Anyone who works in this sector who doesn't realise that we are agents of social control, that we seek to manage and keep a lid on problems or issues for the government that otherwise would be very problematic, is not being particularly honest with themselves.
>
> The drug treatment industry is very much about social control, unexamined social control. You get social workers and psychologists who do not, cannot, will not, accept the perspective of themselves as agents of social control. And this is one reason why we as an industry find it difficult to form effective partnerships with drug user organisations (Respondent 4).

Another service provider, however, felt that the imposition of certain behavioural boundaries on clients was a critical component of addiction treatment, although something that caused philosophical problems for many clinicians

> One of the issues that I struggled with as a clinician, at the risk of being seen to be patronising or unfair, was often I would see clients struggling to make good decisions. Often I would feel the need to put some behavioural boundaries in place to help them structure their lives. That's the problem and tension we have between giving people the freedom of normalisation, which is entirely appropriate and very important, but the practical realities are that the majority of patients continue to struggle, in

> terms of risk behaviour. Where does our duty of care lie? It's juggling those two (Respondent 3).

The above comments by service providers are indicative of the contested nature of drug treatment programs. It is in this discursive environment that there has been a resurgence of the abstentionist movement and their capacity to speak authoritatively on drug policy under the Howard regime has become an accepted 'truth'. Evidence of this is the *'Winnable War on Drugs'* report of the Standing Committee on Family and Health Services which called for a national illicit drug policy that will *'only provide funding to treatment and support organisations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants'* (HOR 2007:xxiii). A similar discourse has been witnessed in the United Kingdom where conservative politicians and interest groups have advocated that abstinence should be the primary aim of drug treatment programs (Ashton 2007). This led to the sacking of a senior government advisor who questioned the increased focus on illicit drugs and the tendency to downplay the comparative harms caused by alcohol (Hinton 2010:28).

The issue of drug treatment programs being a form of social control was something that conversational partners from user advocacy organisations felt strongly about, and one where they felt treatment service providers had little room to move within current government approaches, thereby impacting on the role of illicit drug users in partnerships

> At present pharmacotherapies are used very much as a means of social control rather than as a health service tailored to meet the needs of the clients. Giving more discretion to doctors should help it become more tailored to meet the client's needs. But where there's been such a strong regulatory and punitive approach as part of the culture of service provision that's going to take a while to shift (Respondent 9).

The resurgence of abstinence based advocacy groups such as Drug Free Australia and their increased capacity to successfully lobby conservative politicians, as discussed previously, has made it difficult for drug treatment service providers to exercise

clinical judgement and use discretion in pharmacotherapy prescribing practices. This was discussed in Chapter Two where I argued that a key feature of neoliberalism was a concern about 'expert enclosures' that had developed under the 'welfarist' approach of early liberalism. Neoliberal forms of government sought to permeate these enclosures through a process of 'marketisation' (O'Malley 1996; Rose 1993, 1996a, 1999). This gave them greater control over the allocation of funding to services that had an ideological orientation more in line with their own. This is further evidence that moral and political issues impact significantly on the treatment of illicit drug users, supporting the view of several conversational partners that pharmacotherapies are indeed a form of social control. As one service provider put it when discussing moves to limit the time people could spend on pharmacotherapy programs

> Imagine the PM [Prime Minister] coming out and saying we will have moral based decisions about who we will give insulin to. The morally correct diabetics will get insulin, but they will get it for a year. It's just silly. I think in terms of public health it's a no win policy game (Respondent 3).

The comments made by conversational partners discussed in this section again show that a governmentality framework is a useful analytical tool for examining the role of illicit drug users in partnerships. The comments about drug treatment programs being a form of social control reflect a sense of the 'conduct of conduct', a key concern within governmentality studies. As discussed previously governmentality studies are also concerned with the various technologies employed to maximise the attributes of a population and pharmacotherapies are a prime example of one such technology. Pharmacotherapy programs also enable surveillance technologies such as urine testing as well as bringing people on the programs under the watchful gaze of state sanctioned authorities such as doctors and pharmacists, what I have described elsewhere as a 'pharmaceutical panopticon'. A primary focus of governmentality studies is the rhizomic surveillance networks dispersed throughout the social body and pharmacotherapy programs are an exemplar of this.

During the interviews several conversational partners, when discussing drug treatment programs, also talked about how they sensed an increased moral conservatism in contemporary approaches to drug treatment programs, with a growing push to tailor treatment programs towards making people 'drug free', as indicated by the comment made by the conversational partner immediately above. It had been noted some years earlier that 'we may also be witnessing a resurgence of moral definitions in the discourse on drugs' (Hamilton 1993:361). In the following section I discuss some of the comments made by conversational partners relating to this theme.

7.5 A New Moral Conservatism?

The impact of conservative moral views on contemporary illicit drug policy and treatment programs was another theme that arose several times during the early stages of the interview process and one I followed up on as the process progressed. It was felt by some conversational partners that there had been a discernable shift towards a more morally conservative approach in the policy arena but that this had not generally translated to the service delivery sector. One service provider expressed this view of how things had changed in recent years

> There has been an increased push towards abstinence based approaches, but I don't know to what extent it's been embraced by the field. I haven't noticed any shift among my colleagues but in the political field that's the jargon. I wonder to what extent it is to appease the international arena; obviously the Americans have a strong influence at a political level, at the federal level. But the PM obviously has his own views and harm reduction obviously doesn't sit comfortably with him (Respondent 3).

One conversational partner involved in policy development also felt there had been a shift towards a more morally conservative approach to drug policy and also noted the geopolitical influences which impact on our domestic policy

> Funding in recent times to conservative lobby groups like Drug Free Australia and the contacts that these people have with policy makers is also indicative of a shift, not necessarily just in Tasmania but more

> broadly. There's no doubt we are influenced politically by what's happening in the United States (Respondent 2).

Conversely, one service provider felt Australia had, to some extent, largely avoided the influence of conservative moral views on drug policy. This conversational partner noted the role of some faith-based organisations, which might be considered to be traditionally morally conservative, in developing innovative approaches to reducing drug related harm

> Generally speaking Australia has done better at separating issues and limiting the muddying of the waters by moral debates and the influence say of the church. In many ways the church has been very supportive. Look for example at what St Vincent's lets Alex Wodak do. So credit where it's due (Respondent 3).

The Medically Supervised Injecting Centre (MSIC), the first service of its type in Australia and to date the only one, was established under the auspices of the Uniting Church. Prior to the establishment of this service St Vincent's Hospital in Sydney, under the auspices of the Sisters of Charity, had been granted a licence to operate a similar service only to see it vetoed at the 11th hour by direct intervention from the Vatican (Herbert 2004:95). This again highlights the contested nature of drug policy, even among those who might be traditionally labelled as moral conservatives, and also the influence of geopolitical factors on efforts to develop services that respond to local needs. Even the name for the service that was eventually established was the topic of some debate with the eventual title, 'Medically Supervised Injecting Centre' reflecting a more politically palatable option aimed at appeasing opposition (Herbert 2004:97).

Several conversational partners from user advocacy organisations felt that there had been a noticeable increase in conservative approaches to drug policy during the Howard era that impacted on the effectiveness of partnerships with illicit drug users

> I think one thing when Howard got into power that I woke up to, I had thought that people had become more tolerant and more accepting of

> diversity, but no those people had just kept their heads down in the politically correct years. Then once they had a conservative government they found it safe to express less informed and less tolerant views on drugs and other issues. The anti-harm reduction lobby, such as Drug Free Australia [DFA], is an example of this. The government says it's not interested in giving people money to lobby yet DFA were given $16 million, or whatever, to lobby. And they've done well out of it, they even got a Parliamentary inquiry happening which they've been working towards for several years now (Respondent 9).

> I think in bodies like the ANCD [Australian National Council on Drugs], because those positions are appointed by the Prime Minister, I think that reflects an increased conservatism (Respondent 14).

> I've noticed this kind of turn, because I was away from this type of user advocacy work for a few years and I went to a meeting a few weeks ago with the Commonwealth, and noticed that they really stymie us in our work. It seems to have become a hell of a lot more conservative. Just the difficulties we face in getting resources approved. And that's something that is all very new (Respondent 10).

A conversational partner working in policy development also believed there had been a shift towards a more conservative approach to drug policy - one that supported abstinence based and prevention approaches, in favour of harm reduction that had been the focus of strategies in the past

> During the tenure of the current [Howard] government there has been a move from strongly supporting harm minimisation and harm reduction to more of a focus on preventing the uptake of drugs. And this has moved into the contractual arrangements and service agreements with the Commonwealth and States where programs are required to demonstrate that they support drug prevention initiatives, so it's very clearly weighted

> in that direction and moving more to a zero tolerance position (Respondent 2).

From their perspective the renewed, morally charged, zero tolerance approach to drugs served to undermine the willingness of illicit drug users to participate in partnerships and was likely to lead to more drug related harms

> By continuing to emphasise the abstinence based view we are going to continue to alienate those people [drug user advocates] which will add to the social problems caused by substance use which in my view is a far greater harm (Respondent 2).

Another conversational partner with many years experience working in service delivery and policy development in Tasmania felt that morally conservative views about people who use illicit drugs was another significant impediment to developing effective partnerships with illicit drug users

> The really crushing thing in terms of consumer involvement is the moralistic view of drug use, and it's from such senior people. And that's why you have to admire organisations like TasCAHRD [The Tasmanian Council on AIDS Hepatitis and Related Diseases] that have done some real harm reduction work in really difficult circumstances because their funding is provided by the government, by the bureaucrats, who are opposed to what they are doing (Respondent 13).

The comments and discussion included in this section highlight the contested nature of drug policy and the impact of moral and political issues in this field. As with other themes discussed previously there was no significant correlation between the role conversational partners had in the 'drug policy community' and the views they expressed. Rather the view that there was a 'new moral conservatism' that influenced policy and impacted negatively on partnerships was shared across all three cohorts. The comments also demonstrate how a governmentality theoretical framework can be useful for the analysis of illicit drug policy, due to its focus on the rationalities, technologies and strategies that form part of 'the art of government'.

7.6 Expert Authority and Evidence Based Policy

The notion of evidence-based policy and the role of experts in shaping illicit drug policy and service delivery models was another recurring theme arising during the interviews. As discussed in previous chapters, Foucault traced how under 19th century liberal forms of rule expert authority became intrinsically linked with the formal political apparatus. The political apparatus invested a variety of expert bodies with the authority to act on its behalf in establishing acceptable norms of conduct. This enabled populations to be governed in a more indirect manner, ostensibly providing a greater level of individual freedom consistent with liberal principles (Foucault 1984a, 1994a). Nikolas Rose (1993, 1996a, 1999) argued that neoliberal regimes have sought to detach 'experts' from the political apparatus and situate them 'within a market governed by the rationalities of competition, accountability and consumer demand' (Rose 1993:285).

The *'Winnable War On Drugs'* report (HOR 2007) discussed in Chapter Five highlights the difficulty neoliberal regimes have when their agendas and those of experts in the 'market' do not align. The report attacked people working in the illicit drug field who advocated for a harm minimisation approach. The report disparagingly labelled these advocates *'drug industry elites'*, arguing that their involvement in policy development was *'undermining the implementation of the Commonwealth's stated "zero tolerance" approach to illicit drugs'* (HOR 2007:97). This was in spite of official Government policy documents claiming that harm minimisation remained the guiding principle of Australia's approach to illicit drug use since 1985 (MCDS 2004). This report supports the argument by Rose (1993, 1996a, 1999) about how when 'expert enclosures' developed that were not in line with the ideological position of the government they sought to permeate them through technologies such as 'contractualism' in an attempt to maintain power.

As discussed previously one of the cornerstones of Australia's effective response in containing the spread of HIV/AIDS was the development of meaningful partnerships with 'affected communities' such as gay men and people who inject drugs. The

involvement of these 'affected communities' and the recognition of the expertise they could contribute to policy development and service delivery planning has been noted in a number of evaluation reports commissioned by government agencies as being a key factor in this success (ANCARD 1999; Feachem 1995; Hinton 2010; Single and Rohl 1997). The various documents analysed in Chapter Five make numerous references to the need for continuing with this evidence-based approach.

Conversational partners from user advocacy organisations, however, felt that the concept of evidence-based policy was something that politicians used in a selective manner to push their own policy agendas

> While there's plenty of evidence to support the efficacy of such things as needle exchange you still have people like Bronwyn Bishop [Chair, Standing Committee on Family and Human Services] trotting out her evidence to disagree with that. We have years of evidence accumulated now, much of it funded by people who disapproved of this approach but they've now come to the conclusion that it does work. Everybody running for office has to show their red badge of courage for being a drug warrior (Respondent 9).

Another user advocate expressed a similar view

> The notion of evidence-based policy is pretty much 'window dressing'. It depends on whether it suits them or not. It's the same as partnerships, it's the same as consumer involvement. If the evidence supports what they are saying, or the policy or the direction they want to go then they will pull it out. But otherwise no (Respondent 5).

As discussed in Chapter Three, a number of researchers (Hughes 2007; Marston and Watts 2003a, b; Ritter 2009) argue that the concept of evidence-based policy is itself the topic of much debate and, far from being a rational and value-neutral process, is subject to hierarchical power relations and competing political ideologies. One service provider expressed this view of an apparent reluctance to gather evidence, or trial innovative approaches that might inform good public policy

> We have an enormous amount of evidence from around the world around safe injecting facilities and heroin prescription that shows they work so well. They reduce crime. They reduce the incidence of blood borne viruses. They make enormous savings for the health budget. There's so much research that's been done and they're still going "we're not sure if this is a good idea" (Respondent 11).

These comments illustrate the selective nature of the evidence that informs the policy development process relating to illicit drugs and how governments can choose to ignore evidence that does not suit their ideological position. The heroin trial proposed for Canberra which had been approved by the Ministerial Council on Drugs and had the support of most State Health Ministers only to be vetoed by Prime Minister Howard, is another example of how 'vested interests and dominating agents' (Moore, M. 2004b:49) use their influence to undermine rational policy processes. One conversational partner described the reluctance to trial heroin prescription as based on conservative moral grounds rather than being evidence based

> The proposed heroin trial in Canberra was opposed on moral grounds that it would send the wrong message. No evidence was presented as to why it might send the wrong message so there is no data available that says this might be how young people interpret a heroin trial (Respondent 1).

This view was also supported by ANCARD which argued the veto was a politically motivated decision, rather than one based on evidence (ANCARD 1999:140).

Recent promising results from clinical trials of prescribed heroin in the UK, which has had such programs for many years but is considering expanding them, have been described as 'important politically' (Shetty 2008:546) again demonstrating the political nature of evidence based policy in the illicit drug arena.

The political nature of what counts as evidence was discussed by a number of conversational partners from across all cohorts of those interviewed, supporting the arguments of Marston and Watts (Marston and Watts 2003a, b) and others discussed

above. Several of the conversational partners cited the example of drug prohibition to support their view that drug policy is politically driven rather than evidence based

> Government is very selective about what evidence they are prepared to give any weight to. And the evidence of the failure of prohibition in the U.S. which has the highest imprisonment rates and its impact on the availability of drugs, the consumption of drugs and drug related harm in the community. That's evidence that anybody can see and look at and make an informed judgement on, but that doesn't seem to come into the picture (Respondent 9).

> In relation to evidence-based policy it is clear that prohibition hasn't worked in reducing the harms from drugs but what it fails to recognise or address is that there will always be some people who use drugs for a variety of reasons (Respondent 2).

Another conversational partner involved in service delivery in Tasmania talked about how the political climate under the Howard Government, and the push for abstinence based treatments by conservative politicians without any sound evidence base, was an impediment to illicit drug users participation in partnerships

> For example you have a Senator, Barnaby Joyce, coming out in support of naltrexone implants, and they haven't been approved for use by the TGA [Therapeutic Goods Administration], or any expert in the field, and he's no expert on treatment but he gets this stuff out there. And that's the atmosphere in the community which must make it harder for people to put their hand up (Respondent 13).

This same conversational partner also commented on what they perceived to be a trend in Tasmania of encouraging people to move from one pharmacotherapy treatment to another, in spite of a lack of clinical evidence to support such an approach, and without any input from consumers

> We have this real push at the moment to move all people from methadone to buprenorphine, and that's not even evidence based. You're flying in the face of evidence trying to find a 'one-size-fits all' program. The evidence shows that different treatments fit different people, but here they are trying to go totally towards buprenorphine (Respondent 13).

One of the primary reasons buprenorphine increased in popularity among policy makers in Australia in recent years was the belief that it would lead to decreased levels of diversion to the illicit market and reduce unsafe injecting of take-away pharmacotherapies, as had been documented with methadone. Evidence suggests this has not been the case, however, and that harmful injecting practices have continued, and may even be increasing (Jenkinson et al. 2005). Again this demonstrates that the concept of evidence-based policy is subject to a range of factors and is far from a value-neutral, rational process. The willingness to trial a range of pharmacotherapies, with the notable exception of heroin, supports the views of Bourgois (Bourgois 2000) and Szasz (Szasz 1974) discussed previously about the moral distinctions made between 'medicine' and 'drugs'.

In this section I have discussed some of the comments made by conversational partners around the issue of evidence-based policy and the impact of political factors on what evidence was taken into consideration, and regarded as 'truth', when developing policy. The issue of power in shaping policy was also raised in relation to this topic and I discuss some of the views expressed by conversational partners with regard to the impact of power on the involvement of illicit drug users in partnerships in the following section.

7.7 Power in Partnerships

A number of conversational partners raised issues of power in partnerships that impact on the capacity of people who use illicit drugs to make effective contributions to reducing drug related harms. As has been discussed throughout this thesis a major focus of Foucault's work was the question of power, and what discourses counted as 'truths' due to their utility in supporting the objectives of those in power (Gordon

1994). Indeed it was during the course of his investigations into political power that he introduced the concept of governmentality (Rose et al. 2006b:83). In recent times the study of power relations in partnerships has attracted growing attention in diverse areas such as urban renewal projects (Hastings 1999), international aid programs (Lister 2000) and health care systems (Milewa et al. 2002). During the interview process the concept of differential power relations in partnerships was another recurring theme raised by several of the conversational partners. Among the conversational partners there were divergent views on which groups within the policy partnerships held the most power, however, it was agreed by all that the least powerful members of these partnerships were people who use illicit drugs.

It was felt by several of the conversational partners that the issue of power related to the levels of government funding each of the different groups that are part of the partnership received

> If you look at the funding arrangements at the Commonwealth level around law enforcement and interdiction they receive the bulk of funding, prevention measures receive a smaller percentage, treatment is smaller again. That means that policing, by having far greater resources is able to invest more time in researching issues and develop policy and strategies, has more opportunity to advocate for their approaches than say a service focused on harm reduction (Respondent 2).

Law enforcement was considered by all conversational partners to have the most power in drug policy partnerships, primarily due to the continued prohibition approach to illicit drugs. Government bureaucrats were considered the next most powerful group, largely due to the fact that they control the majority of funding and determine where it will be allocated.

> Law enforcement has the most power, followed by the health bureaucracy, although I don't think in terms of funding they even come close to what the police get, but they are obviously very influential. But drugs is a poor area within health, so the health bureaucrats within this area probably feel pretty disempowered themselves (Respondent 9).

> So if you are looking at the police/health partnership, I will call it a relationship because it is not an equal one. I would suggest that in Tasmania at this point police have far more influence in terms of government policy direction (Respondent 2).

As mentioned at the beginning of this section among all the conversational partners who discussed the issue of power relationships it was agreed that the least powerful members of these partnerships were illicit drug users. The comments from members of user advocacy organisations below summarise the general view of the power that users have in these partnerships

> Take our relationship with government, they control the money which we depend upon to do our work. When they say this area is no go – we cross that line and we don't get it. Within those parameters we try and do what we can but there's no pretence that it's an equal partnership or that we have equal power (Respondent 9).

> Bureaucrats and police have heaps more power in partnerships than affected communities. Like if there's a consumer representative at a committee and there's also police and bureaucrats, that person is sort of there on their own and they have to identify this illegal behaviour (Respondent 5).

In this section I have highlighted the views expressed by conversational partners relating to the issue of power in partnerships. The amount of funding partners received was felt to reflect the level of power they had in influencing policy. An analysis of expenditure on illicit drug-related activities in Australia in 2002/03 supports the views expressed in the interviews. This analysis found that law enforcement activities received the greatest amount of funding, $558.9 million. Prevention programs received $303.9 million and treatment programs received $229.2 million. Harm reduction activities, which included strategies such as needle and

syringe programs, outreach work, HIV and hepatitis education and information, and overdose prevention activities received $55.4 million (Moore, T. 2005). These figures demonstrate that the majority of expenditure is heavily weighted towards enforcing the prohibition of drugs, while activities aimed at reducing the harms associated with illicit drug use, which receive less than 10% of the law enforcement budget, are very much the 'poor cousins' in partnerships. Governmentality studies acknowledge 'the complexities, subtleties and micro-negotiations of relations of power' (Petersen 1997:203) and the discussion in this section again supports the utility of a governmentality framework of analysis for partnerships and power in the illicit drug field. In the following section of this chapter I discuss a theme related to the issue of power that was raised by a number of conversational partners, this being the silencing of the voices of user advocates voices.

7.8 Silencing Dissent

The issue of an apparent increase in silencing the voices of user advocacy organisations was another recurring theme raised in the interviews, predominantly by user advocates but also by some policy makers. This was usually done through implicit threats about funding cuts if these bodies spoke out too much about a range of issues relating to drug related harms. Partnerships are often the site of power struggles and one of the most powerful tools used by government is the threat of funding cuts to 'partners' who speak out against perceived flaws in policy development and service delivery planning processes. As discussed in Chapter Two, Gordon (1991) argued that Foucault's view of power meant that to work with government did not mean compliance or agreement on common problems.

As discussed in Chapter Three a study conducted by The Australia Institute, a left-wing think tank, found that there had been an increasing trend during the tenure of the Howard Government where 'a pattern has emerged in which the Federal Government has set out to stifle democratic debate. It has been highly effective at silencing, or at least muting, its critics in civil society' (Maddison et al. 2004: 44). The study found that among non-government organisations, there was 'widespread alarm … about

their lack of ability to speak in support of those they represent without risking revenge in the form of personal abuse from Government representatives, public disparagement and withdrawal of funding (Maddison et al. 2004:43). The study found that most organisations surveyed felt there was a real risk that if they spoke out against government policy their funding could be jeopardised. The comments made by conversational partners below support these findings

> It was a political decision to defund the user group in this state. And it's made the process of having consumer input really difficult now. We weren't really that popular and were making too much noise, we were too outspoken. It was like you were offered a seat at the table and expected to think that's good enough but we didn't expect you to come and represent your view and object to this policy and want change. You should be happy that you've got a seat (Respondent 5).

Another conversational partner from a user advocacy organisation highlighted the dilemma faced by their organisation around advocating on behalf of its constituents. This organisation's funding agreement related to providing policy advice to government and services to clients, but they had been specifically told funding was not for the purposes of advocacy

> We provide advocacy but we are not funded as an advocacy group. Government fund us to provide advice to them, not to lobby against them. And that really is compromising for any funded community group (Respondent 9).

A conversational partner who worked in a policy role shared the views of those expressed by user advocates

> I don't think we can get away from the fact that there has been a concerted effort at the Federal level to reduce the advocacy role of interest groups across social policy areas (Respondent 2).

A service provider also felt there had been a noticeable trend towards silencing dissenting views in the policy arena that impacted on the capacity of user advocates to work effectively in partnerships

> If you hear peak bodies in the media being careful not to tread on funding bodies toes for fear of upsetting them, then what hope has a user got of getting up and saying something if treatment bodies aren't willing to speak out (Respondent 13).

The role of non-government organisations is crucial in neoliberal democracies as they are critical in giving voice to the needs of marginalised groups. From a governmentality perspective they play an important role in neoliberal regimes attempts to 'govern at a distance'. The role played by AIDS advocacy organisations in the early days of the HIV epidemic in Australia is evidence of this (Ballard 2005). Silencing the voices of drug user advocates poses a significant barrier to engaging them effectively in partnerships and serves to undermine their credibility in the eyes of the marginalised constituents they seek to represent. As Friedman (1998) argues, such an approach may be a rational, calculated way of defending the vested interests of the powerful and deflecting attention from failed social policies, reflecting an 'authoritarian liberal' approach to governing drugs as discussed elsewhere.

7.9 Illicit Drug Users and 'The Conduct of Conduct'

As discussed previously in Chapter Two, governmentality studies are concerned with the 'conduct of conduct' (Dean 2007; Foucault 1994a; Osborne 1997; Rose 1996a). Governmentality scholars seek to analyse the 'rationalities' behind various government programs and the strategies and technologies brought into play to achieve desired outcomes. As also discussed in detail in Chapter Two Dean argues that neoliberal regimes make divisions between 'those capable of bearing the freedom and responsibilities of mature subjectivity and those who are not' (2007:118). Those whose capacity for self-government has been deemed to be undermined by substance use are subjected to a form of 'authoritarian liberalism' (Dean 2007:108-129). Several conversational partners discussed issues relating to drug treatment programs that

illustrated a sense of guiding the conduct of program participants. While this related more to individuals than to drug user advocacy organisations it demonstrates the utility of a governmentality framework for analysing drug treatment programs and how this impacts on partnerships with people who use illicit drugs.

In all States clients on pharmacotherapy programs are required to sign some form of 'contract' relating to expected behavioural standards during the course of their treatment. These usually include a requirement for regular urine testing that will detect any use of illicit drugs while on pharmacotherapies – part of what I have described as a 'pharmaceutical panopticon'. The resources provided to individuals who enrol in methadone programs outline a number of benefits for consumers to support them in making informed choices about their treatment (Fraser and Valentine 2008). This aims to overcome the notion of coercion associated with compulsory treatment programs and seeks to further extend the governance of drug users by helping them develop the skills deemed necessary to reduce risk, or what O'Malley describes as 'governing through choice' (1999a:205).

Conversational partners from user advocacy organisations felt the requirements of pharmacotherapy programs were a significant imposition on people in treatment and were symptomatic of a widespread stigma attached to being addicted to opiates and typical of 'authoritarian liberal' responses to social problems

> [The Health Minister] believed a lot of the media hype and backed the imposition of really draconian treatment agreements so that when you went into treatment you had to sign this bit of paper that said I'll be good and turn up on time, etc. It was almost like signing a parole form or something. And this was a decision made in the Minister's office that there would be these treatment agreements, taking a leaf out of the social contracts in the UK that Tony Blair's government put in place (Respondent 6)

Under neoliberal regimes individuals who behave in a manner not deemed 'risk-free' are often considered as failing to meet their obligations as responsible citizens

(Petersen 1997:198). As discussed previously it has been argued that this leaves them open to a range of sanctions (Dean 1995; Wodak et al. 2004), often with a strong moral undertone (O'Malley and Mugford 1991a:127).

Conservative politicians and lobby groups such as Drug Free Australia calling for a review of drug treatment programs, arguing for restrictive measures such as disallowing the provision of takeaway methadone doses for people who have children living in their household, demonstrate this. In addition it was argued that adoption should be the 'default' care option for children who have parents that use illicit drugs when a notification has been made to child protection authorities (DFA 2007; HOR 2007). This prompted some alcohol and drug experts to caution that such a move could create another 'stolen generation' of Australian children (Parry 2008). Further, the Coalition election policy on illicit drugs in 2007 called for the quarantining of welfare payments for people convicted for illicit drug offences (Liberal Party of Australia 2007:4). These are just some examples of recent attempts by government to guide 'the conduct of conduct' and again illustrate how current approaches to illicit drugs can be usefully analysed using a governmentality framework. It also highlights the utility of the concept of the 'political economy of drug user scapegoating' (Friedman, S. 1998) that has been discussed in detail throughout this thesis.

7.10 Summary

In this chapter I have discussed findings from the interviews in which conversational partners identified a range of factors that impact on the effective engagement of illicit drug users in policy development and service delivery partnerships. These build on the issues identified in the previous chapter that identified barriers and enablers to successful engagement in partnerships.

The recurring themes arising from the interviews discussed in this chapter have been: the representation of users and the struggle for legitimacy in advocating on behalf of people who use illicit drugs; the 'politics of prohibition' and the impact this has had on partnerships, particularly in recent years in the "Tough on Drugs" discursive environment; and the governmentality concept of the 'conduct of conduct' and

pharmacotherapies as a form of social control. I also explored the views expressed by conversational partners about a sense of a 'new moral conservatism' having an increased influence on discourse relating to illicit drug use, the concept of evidence-based policy, power relations in partnerships and the silencing of dissent. Throughout the chapter I have argued that a governmentality theoretical framework provides a useful tool for analysing the concept of partnerships in the illicit drug field.

As was the case with the themes analysed in the previous chapter, no clear pattern emerged to indicate that the views expressed by conversational partners were related to their role in the 'drug policy community'. Again it was evident that there are a number of barriers that make it challenging for user advocates to participate in partnerships in a meaningful way. Conversational partners from all three cohorts expressed these views during the interviews. In order for a consumer advocate organisation to operate effectively in Tasmania, as proposed in the *'Future Service Directions'* document (DHHS 2008), the issues identified in this chapter are critical for developing a sustainable peer-based organisation.

Chapter 8 – Partnerships - Rhetoric or Reality? Where to Next?

8.1 Conclusion

This research set out to analyse how effective the concept of involving people who use illicit drugs in partnerships had been. By adopting a Critical Discourse Analysis approach to a range of relevant policy documents, the research was able to develop a genealogy of the concept of partnerships involving people who use illicit drugs and situate them within a neoliberal governmentality approach to social policy. This approach enabled 'ruptures' evident in the discourse of partnerships involving illicit drug users to be identified and the social processes impacting on this to be examined. Through in-depth, conversational style interviews with policy makers, service providers and people from drug user advocacy organisations who were members of these partnerships, the research was able to identify the limited success of such an approach and key factors contributing to this. By adopting a thematic analysis approach to the interviews the research was able to identify key themes emerging from these interviews that impacted on the involvement of users in partnerships. This dual approach to examining the concept of partnerships, a method described by McKee as a 'realist governmentality' (2009:478) approach, enabled me to develop an understanding of how the policy documents played out in 'the real world'.

8.2 The Success of Partnerships?

The research finds that the involvement in partnerships of people who use illicit drugs in developing effective responses to the issue of drug related harms was, for the most part, little more than a rhetorical device used by neoliberal forms of government to convey a sense of inclusion of affected communities in developing responses to drug related harms. As has been discussed previously politicians commonly use rhetoric and metaphor as a communication tool to legitimise their actions (Charteris-Black 2005). There were, however, a few notable exceptions. These included the role people who use illicit drugs played in keeping the prevalence of HIV/AIDS among injecting drug users low as a result of their involvement in the initial response to the virus, and

the development of effective responses to drug overdoses in partnership with health and law enforcement agencies. The failure to learn from these successes, however, was found to have been a significant impediment to more meaningful engagement with people who use illicit drugs in partnerships in recent years.

As discussed in Chapters Six and Seven, there were mixed views among those interviewed as to how successful the concept of involving people who use illicit drugs in partnerships had been, particularly at the level of policy development. However, the exceptions noted above were recurring themes that arose during the interviews, and are well documented in the literature reviewed as part of the research process. One only has to look at the example of the USA where HIV rates among injecting drug users remain high due to policies that restrict needle and syringe availability while the response in Australia, which involved injecting drug users, has seen a far lower prevalence among injectors. The role people who use illicit drugs played in overdose reduction initiatives in Australia has been less well documented (Wodak 2005) but was another recurring theme raised during the interviews. As discussed in Chapter Six, the role interviewees played in partnerships - whether it was policy maker, service provider or user advocate – were not differentiating factors and all three cohorts shared similar views about these successes. Some examples were given where users were given a seat at policy-making forums, although not at high-level forums that could influence significant change. A small number of one-off examples where people who use illicit drugs had been involved in service delivery planning were also cited during the interviews.

As also discussed in Chapter Six, negative views of the success of partnerships involving people who use illicit drugs were much more widely held. Again this was not dependent on the role the interviewee played in these partnerships but was a common theme across all three cohorts. The involvement of users was felt to be sporadic, at best, and there was a widely held perception that their involvement was largely a rhetorical tool used by government to convey an impression of inclusiveness consistent with contemporary neoliberal models of best practice policy development and service delivery planning, a defining feature of the' New Public Health' (Petersen

and Lupton 1996). In Tasmania the involvement of users in partnerships was considered to be virtually non-existent and this had resulted in poor policy outcomes, as well as poorer health outcomes for users.

8.3 Barriers and Enablers Impacting on Partnerships

The research identified factors that impacted on the involvement of people who use illicit drugs in partnerships. During the analysis of the interviews these were classified as 'enablers' and 'barriers'. These were discussed in detail in Chapter Six and are briefly summarised in the following section.

8.3.1 Enablers – Institutional Support, Users Expertise and Policing

Adequate resourcing and institutional support for user organisations was a recurring theme in the interviews that was considered an 'enabler' of successful partnerships. This resourcing included both adequate funding of organisations as well as supporting the professional development of user advocates through mentoring processes. Where users did have a role in policy forums it was felt critical that they were adequately supported in order for them to fully participate in these forums, a process that could often be confronting for users, particularly when law enforcement personnel were at the same table.

Another key enabler was recognising the unique expertise that people who use illicit drugs could contribute to government efforts to reduce drug related harms. This is consistent with Foucault's notion of the 'specific intellectual' who 'begins to intervene in contemporary political struggles in the name of a "local" scientific truth' (Foucault 1994c:129). Recognising the expertise of illicit drug users in developing appropriate resources and acting as a conduit between government and 'affected communities' were considered key 'enablers' of partnerships. Recognising the expertise of users as peer educators also facilitated 'governing at a distance' a defining feature of neoliberal governmentality approaches to rule. Fraser and Valentine (2008:127) argue that the specific expertise of illicit drug users shares similarities with other health consumer movements, such as in mental health and

disability services, and may offer possibilities for improved prospects in the future. Hinton's (2010) research into consumer involvement in the United Kingdom made similar findings.

The final key 'enabler' to partnerships identified by several participants in the interviews was the support of law enforcement agencies for a partnership approach. Several conversational partners cited this as a critical factor in the success of needle and syringe programs, as well as in the development of protocols relating to overdoses discussed in Chapter Six.

8.3.2 Barriers – Resourcing, 'Enabling Environments' and Provider's Attitudes

The research finds there were a number of 'barriers' to successfully involving people who use illicit drugs in partnerships, and conversational partners noted many more 'barriers' than 'enablers' existed. As discussed above institutional support was a critical factor in enabling people who use illicit drugs to participate in a meaningful way in partnerships, however, it was also identified as a significant 'barrier'. A lack of political will was cited as a key barrier to adequately resourcing user organisations, particularly in Tasmania. Several conversational partners felt that there was little for politicians, or bureaucrats, to gain by supporting user organisations other than to empower a potential adversary. Other interviewees discussed how there was little political traction to be gained by being seen to be supporting drug users, and that to be seen to support such a marginalised group might be fraught with risk due to the nature of our system of democratic government.

Another barrier identified as a recurring theme in the interviews was the lack of an enabling environment, as outlined in the *Ottawa Charter for Health Promotion* (WHO 1986), in which people who use illicit drugs could effectively operate in partnerships. This also related to the lack of political will and lack of leadership by governments to foster an environment in which user advocacy organisations could work effectively in partnerships to reduce drug related harms. As with the concept of partnerships, it was felt the concept of an 'enabling environment' was merely another rhetorical tool used by governments to display a veneer of seeking to reduce harm

while the reality was the environment in which user organisations operated was far from enabling. The lack of institutional support to user organisations was again cited as an example of this, with funding agreements to user organisations generally not including funding for advocacy work. Conversational partners felt this served as a powerful disincentive to actively advocate for meaningful change and was symptomatic of an increase in the Howard Government's efforts to silence dissent (Hamilton & Maddison 2007a; Maddison et al. 2004) as discussed in chapters Three and Seven.

This was felt to be especially strong in Tasmania where funding to peer-based user organisations is non-existent, and people who use illicit drugs were heavily dependent on developing strategic alliances with sympathetic individuals in government departments, of whom there were considered to be very few. Rather than the Tasmanian Government seeking to support the establishment of a peer-based service to represent the interests of people who use illicit drugs, it has chosen what appears to be a much more politically palatable option. The awarding of a tender to Advocacy Tasmania, a non-peer based organisation with no history of working with people who use illicit drugs, other than those with co-existing mental health issues, supports this view. It also reflects a continued pathologising approach to substance use, as discussed in Chapter Two, where there is no recognition of the possibility of functional forms of substance use. In effect this is likely to lead to a failure of attempts to 'govern at a distance' due to the exclusion of those people who use illicit drugs who are not in treatment or don't need treatment (Brogan 2010; Madden 2010).

Another recurring theme in the interviews was the negative attitudes of service providers towards their clients. Again this was perceived to be a significant barrier to partnerships, particularly in Tasmania where a reluctance to employ peer workers was seen as symptomatic of a systemic distrust of the client group. As Philips and Bourne (2008) argue, workers attitudes can have a significant bearing on client outcomes within treatment services. It was felt by several of the conversational partners that many people working in the treatment sector held a stereotypical view of people who use illicit drugs as 'mad, bad and dangerous to know' (Ross and Darke 1992).

Another issue relating to workers in the sector was a perception that breaches of confidentiality were common and this made clients reluctant to access services, particularly at sites where a range of services, such as counselling and needle exchange, were co-located. Again, it was felt that this perception, whether real or not, proved a barrier to successful partnerships and was a significant issue that needed to be addressed, particularly in a small jurisdiction like Tasmania where degrees of separation between worker and client are usually smaller than in other States.

8.4 Other Issues Impacting on Partnerships

During the interviews conversational partners discussed a range of other issues that impacted on partnerships that they felt limited the effective involvement of people who use illicit drugs. In the following section I summarise these and argue that they are important factors for understanding partnerships in contemporary neoliberal regimes.

8.4.1 Representation of Users

Who was best placed to represent the interests of people who use illicit drugs was an issue raised during a number of the conversations. Illicit drug users are a heterogeneous population coming from a range of socio-economic backgrounds. They consume a range of different substances and have a variety of aspirations, desires and needs. For some their drug use is problematic and they seek or, in some instances, are diverted by law enforcement agencies towards treatment services. For others their use of illicit drugs is little more than a recreational pursuit, something that enhances their consciousness (a practice of the self?), a matter of curiosity, or a form of self-medication to alleviate a condition of one type or other. This group of drug users rarely, if ever, come into contact with mainstream treatment services. For many users the only contact they have is with providers of sterile injecting equipment in community-based NSP outlets. This was identified during the interviews as a factor that potentially undermined the legitimacy of existing user organisations, as well as being an impediment to establishing any sustainable organisation in Tasmania where no peer-based organisation exists.

As discussed above, the recently established service operated by Advocacy Tasmania and funded by the Tasmanian Government targets consumers of drug treatment services and, therefore, can only legitimately represent the interests of those currently in treatment. Advocacy Tasmania's mandate also covers those in treatment for alcohol and tobacco related issues resulting in a less specialised focus as well as less resources for targeting illicit drug related issues. Consequently the majority of people who use illicit drugs remain unrepresented in policy development and service delivery planning processes in Tasmania. This failure to adequately address these margins (Rose 1996c, 1999) is likely to translate into a continuation of a form of 'ungovernability' of drug users. The peer-based services operating in Victoria and NSW have a broader mandate by including all people who use illicit drugs in their target group, not just people in treatment. Harm Reduction Victoria also operates a government-funded program that advocates on behalf of pharmacotherapy consumers and mediates when disputes arise between them and their service providers. This model was cited by several of the conversational partners as approaching the ideal, albeit with some limitations due to resourcing issues. From a governmentality perspective this is a more effective way of 'governing at a distance' as it potentially has a far greater reach.

8.4.2 'Tough on Drugs' Discourse

The 'politics of prohibition' and the continuing 'war on drugs' was another recurring theme identified as an impediment to effective partnerships involving people who use illicit drugs. This was felt to have become more evident since the Howard Government introduced its "Tough on Drugs" policy. The increasingly marginalised status of drug users that resulted from this discourse was identified as a factor in them not having access to those in positions of power that could influence any significant change, as had been the case with gay men when HIV/AIDS became a prominent social issue (ANCARD 1999; Ballard 2005).

The increased focus on comorbidity in recent years, and the perpetuation of the view that all illicit drug use was pathological, with no recognition of the 'functional user',

was viewed as another result of this prohibitionist discourse that served to undermine the involvement of users in partnerships. Prime Minister Howard's hand-picked ANCD, discussed in detail in previous chapters, was cited as an example of this, and the failure to include a representative of people who use illicit drugs on this body was seen as an indication that the Government was not committed to fostering meaningful partnerships with people who use illicit drugs. Finally, the fact that it could be potentially damaging for a politician to be seen to be 'soft on drugs' if they were to propose any change from the current approach was considered a further impediment to partnerships involving people who use illicit drugs.

Another recurring theme in the interviews was a sense among conversational partners that a new moral conservatism was evident in recent years in the illicit drug policy arena. The increased push for abstinence based approaches to treatment, driven primarily by faith-based organisations, and the prominence abstinence advocates had gained in the drug policy arena was cited as evidence of this. The fact that the head of the ANCD, a key supporter of abstinence based approaches, was also from a faith-based organisation, was felt to be another indicator of this (Macintosh 2006). Funding to conservative lobby groups such as Drug Free Australia, who also had a seat on the ANCD, was viewed as part of a wider trend towards a morally conservative approach to drug policy that negatively impacted on the involvement of people who use illicit drugs in partnerships. This was seen as part of a wider political agenda of the Howard regime that saw the Religious Right gain increasing influence (Maddox 2005). This seems to have continued since the new Prime Minister, Julia Gillard, admitted she was an atheist and has subsequently been widely criticised by church leaders for her beliefs.

In the interviews conducted as part of this research several people expressed a view that involvement of users in partnerships had been more successful in the HIV/AIDS sector than in the HCV sector. It was felt that this was partly due to the longer period of time that users had been involved in HIV/AIDS partnerships but also because of the stigma attached to illicit drug use, even though the majority of HCV infections are caused by injecting drug use. Nonetheless, it was felt that partnerships in both these

sectors were far more successful than in the drug policy arena, largely due to a genuine commitment to the concept of partnerships that was felt to be lacking in the drug policy sector and which had become more apparent under the Howard Government's "Tough on Drugs" approach. A significant factor in this was thought to be the increasing influence in the policy development arena of advocates of zero tolerance and morally conservative approaches to drug issues, and the constant undermining of Australia's harm minimisation policy by such actors. Proponents of this discourse consider illicit drug use as a moral failing, rather than a health issue, and support law enforcement and prevention of drug use above harm minimisation (Mendes 2008).

8.4.3 Evidence Based Policy or Policy Based Evidence?

The concept of evidence-based policy was also raised by a number of conversational partners, from both a positive and negative perspective. The positive perspective was that there was a growing body of evidence to support the involvement of 'affected communities' in developing effective responses to health issues as well as to continue harm reduction strategies such as needle exchange programs. Some spoke of the encouraging evidence coming from overseas where heroin prescription was proving to be an effective treatment modality. It was felt that such a growing body of evidence could not be ignored forever and that a more rational approach to drug use would eventually prevail. The negative perspective was that politicians were prone to use evidence in a selective manner that suited their own agenda. The failure of a 'war on drugs' approach, such as in the USA, was raised by several interviewees as an example of the politically contested nature of evidence, and concerns were expressed that the release of *'The Winnable War on Drugs'* report by a Standing Committee of the House of Representatives (HOR 2007) would perpetuate this prohibitionist discourse. Concerns were also expressed about the lobbying by abstinence advocates for the introduction of naltrexone implants, in spite of this technology not having been subjected to the rigorous clinical trials normally required before such drug treatments are approved for wider use. The reluctance to trial heroin prescription in Australia was also mentioned as symbolic of a reluctance to gather evidence that may not agree

with the ideological position of those in power. As with the concepts of partnerships and enabling environments, it was felt that evidence-based policy was largely a rhetorical tool of government used to confer a sense of legitimacy on the dominant prohibitionist discourse and was seen as another factor negatively impacting on partnerships with people who use illicit drugs.

8.4.4 Partnerships and Power

The issue of differential power relations in partnerships was another theme discussed by several of the conversational partners. As the theme of power/knowledge was a key focus of Foucault's works this was an area of inquiry I was keen to pursue. There were divergent views on which groups in partnerships possessed most power, although it was agreed by all those who discussed this issue that people who use illicit drugs were the least powerful members of these partnerships. The power each group held within partnerships was considered directly related to the amount of funding each received. Law enforcement agencies were considered the most powerful members of partnerships by virtue of the resources they had at their disposal and this was reflected in the continued pursuit of a prohibitionist approach to drugs. These differential power relations were considered to be another factor that undermined partnerships, as the limited funding made available to user groups severely restricted their capacity to participate in any meaningful way.

8.4.5 Silencing Dissenting Voices

The final key theme raised by several of the conversational partners was the silencing of dissent they believed was becoming increasingly evident in the policy-making arena. This was discussed by all of the representatives from user organisations, as well as some service providers and policy makers, as a factor that severely restricted their capacity to participate in partnerships. Where user groups spoke out against policy decisions they felt a very real threat that their funding would be threatened, one interviewee experienced this first hand and the organisation they belonged to was defunded, only to have this reinstated after a period of time. Others talked about how their funding agreements did not make provision for advocacy work and when they

did this, which they saw as part of their core business, government threatened them that their funding would be cut or withdrawn altogether. In such a climate user organisations found it difficult to operate effectively and this was identified as another significant impediment to them working in partnerships in any meaningful way.

8.5 Governmentality, Partnerships and Illicit Drug Use

The research finds that, for the most part, a governmentality framework of analysis was helpful for understanding the involvement of people who use illicit drugs, albeit one that could be strengthened by incorporating other theoretical perspectives. I proposed an 'ideal governmentality' model, consistent with Weber's suggested construction of an 'ideal type' (Weber 1964:92), and used this to identify how existing approaches deviate from what would be considered a purely rational approach to reducing drug related harms.

In Chapter Five I developed a genealogy of partnerships in the drug policy development process, and argued there was evidence that the increasing sophistication of these documents reflected an increase in a governmentality approach to rule. The processes involved in the development of these policy documents demonstrated an increasing reliance on expert bodies, a defining feature of a governmentality approach. The documents also set out a sophisticated network of surveillance mechanisms aimed at making the phenomena of illicit drug use in the community more knowable and, as a result, more amenable to intervention. Many of the documents analysed also placed a great deal of emphasis on measuring performance against a set of identified indicators, a feature that became apparent in documents from more recent years as a governmentality approach to rule became more refined. Again these surveillance networks and the establishment of measurable performance indicators reflect key characteristics of a governmentality approach.

8.5.1 Governing 'At A Distance' Through Expert Knowledge

The expert bodies established to develop and monitor the implementation of these documents and strategic plans also facilitate 'governing at a distance' whereby

responsibility for addressing problems related to illicit drug use are spread throughout the social body and the responsibilising language used in the policy documents are another feature of a governmentality approach to rule. The establishment of the ANCD by Prime Minister Howard, however, demonstrates that far from being a value-neutral rational process consistent with neoliberal principles, the illicit drug policy process is the site of a great deal of contestation and moral and political factors play a significant role in determining policy. The exclusion of people who use illicit drugs from this major advisory body demonstrates this. This is one area where I feel a governmentality framework of analysis has limitations, and can be augmented by the concepts of 'authoritarian liberalism' and Friedman's concept of 'drug user scapegoating' (1998).

In analysing the various policy documents I traced the evolution of the concept of partnerships involving affected communities and how this supported the establishment of peer-based user organisations to facilitate what Rose described as 'governing the margins' (Rose 1996c, 1999). As discussed above, however, the interviews conducted as part of the research found that a number of barriers existed that impacted on the capacity of these organisations to operate effectively. This became more evident under the Howard Government's "Tough on Drugs" initiative that was felt to have undermined the potential of partnerships involving people who use illicit drugs and shifted the emphasis back to a law enforcement focused abstentionist approach. However while the rhetoric of the "Tough on Drugs" approach strengthened, their was a contemporaneous increase in funding for harm reduction programs such as needle exchange programs, recognising that they played a critical role in reducing drug related harms. This indicates that the pursuit of rational, evidence-based approaches remained in place in some areas of policy, but again political and moral factors also impacted on the process of policy development. I have argued this is one of the inherent tensions of neoliberal approaches to rule.

The notion of evidence-based policy, another defining feature of a rational governmentality approach to rule, was also found to have gained far greater emphasis in policy documents since the introduction of the first NACADA document. As

discussed, however, what counts as evidence is also subject to political and moral factors. Those in positions of power tend to have a far greater say than those in more subjugated positions, such as people who use illicit drugs, to determine what evidence is adopted for the purposes of informing policy development. There was also a reluctance to trial innovative programs that might enable evidence that could inform future initiatives to be collected, as was the case with the aborted heroin trials, which further underlines the political nature of evidence-based approaches to drug policy.

8.5.2 Liberalism – Its Contradictions and 'Dark Side'

The concept of 'authoritarian liberalism' and the negative impact this has on partnerships involving people who use illicit drugs was also discussed. This entails making distinctions between 'the civilized and the marginalized' (Dean 1995:580) and rationalising the adoption of coercive practices in order to 'make-up' individuals fit to bear the freedoms and responsibilities of neoliberal citizenship. Rather than representing an inconsistency with liberal values of freedom and autonomy, this was found to be a common feature of classical liberal political discourse (Hathaway 2002; Hindess 2001; Valverde 1996). This 'dark side' of liberal mentalities of rule makes the governmentality project of maximising the capacity of the resource of population problematic and limits the potential of an 'ideal governmentality' model that might more effectively respond to the harms caused by problematic substance use.

Some of the inherent contradictions of contemporary neoliberal approaches to rule evident in a 'war on drugs' discursive environment were also highlighted in the research. In a society of hyper-commodification (Mugford 1993) in which autonomous citizens develop their identity through their patterns of consumption, and where most forms of consumption are valorised as they contribute to strengthening a state's economy, it is only natural that the allure of the pleasurable effects of drugs are attractive to consumers. The notion of pleasure was, however, found to be notably absent in most neoliberal government discourses on drug use which focus instead only on notions of pathology, pain and compulsion. This has created a market of 'drug entrepreneurs' and 'anti-citizens' who remain outside of the domain of

government control. This is where I consider a governmentality framework of analysis has limited applicability for understanding contemporary responses to substance use.

8.6 Augmenting a Governmentality Framework

The research also finds that a governmentality framework of analysis has some limitations for explaining the limited effectiveness of partnerships and can be augmented by the concept of the 'political economy of drug user scapegoating' posited by Sam Friedman (1998). The political economy framework has also been utilised by Bourgois (2003) and Fraser and Valentine (2008) in their analyses of various aspects of drug policy and was found to be helpful in understanding the persistence of a prohibitionist approach, in spite of a lack of evidence that this was effective. Room (1999) and Levine (2002, 2003) also found that the 'scapegoating' approach adopted by governments served to foster the continuation of prohibition, and my research identifies that in this discursive environment it is difficult for user advocacy organisations to operate in a manner that effectively reduces drug related harms.

I consider this a critical augmentation to a governmentality framework, although one of the most prominent contemporary governmentalitists, Mitchell Dean (1998), has argued that some social policy was based more on political logic than any obvious governmental rationality so there is some recognition of this limitation. For researchers utilising a governmentality framework of analysis for other areas of social policy that are morally contentious, for example abortion or the sex work industry, these limitations should be kept in mind. The perceived weaknesses of a governmentality approach and the failure to engage in the 'messy actualities' of social relations and human practices (Hindess 2005; McKee 2009; O'Malley et al. 1997; Petersen 2003; Stenson 1998), as discussed in Chapter Two, need to be at the forefront of researchers minds when undertaking research in such morally contested fields.

8.7 Moving Forward – An Economic Rationalist Approach to Drug Control

An important starting point for improving the failed policy of involving users in partnerships would be to follow the model adopted in the UK where consumer involvement in service delivery planning is a statutory requirement (Hinton 2010). At the moment in Australia this is not the case and although many Australian State's, including Tasmania, have established Social Inclusion Units within government bureaucracies, the inclusion of people who use drugs does not appear to be a priority, if indeed it is even acknowledged as an issue for such Units. Recognising the need to include users as part of the community would be an important first step towards overcoming their marginalised status and would indicate a genuine commitment to involving them in addressing drug related harms.

The second step would be to recognise the significant barriers that the current prohibitionist paradigm poses to involving users in partnerships, as has been identified in this research. An increasing number of harm reduction advocates, 'experts' working in the drug treatment sector, as well as a number of other 'experts' such as the neoliberal economist, avowed economic rationalist and Nobel Laureate, the late Milton Friedman (1972, 1991), are calling for a change in the way society approaches the phenomena of drug use with a growing number of countries moving towards a more regulated and tolerant approach (Hinton 2010; Levine 2003:145; TDPF 2010). This recognises the catastrophic failure and unsustainability of a 'war on drugs' approach (ICDSP 2010) and resonates with Rowe's view that we are on the brink of a 'policy paradigm crash' (2004b:116) as a result of this. Macintosh argues

> Governments need to admit the deficiencies of prohibition and pursue the changes that the evidence shows will produce better outcomes rather than trying to manipulate drug issues for political purposes (2006:ix).

However, 'a major barrier to drug law reform has been a widespread fear of the unknown, just what could a post-prohibition regime look like?' (TDPF 2010). The UK-based Transform Drug Policy Foundation (TDPF) has developed what it calls a 'Blueprint' for a regulated drugs market. This 'Blueprint'

> envisages a world in which non-medical drug supply and use is addressed through the right blend of compassion, pragmatism, and evidence-based interventions focussed on improving public health (TDPF 2010:xiv).

Such a model would see the enormous profits that are currently being earned by black market 'drug entrepreneurs' redirected towards state coffers and enable better funding for effective treatment, as well as significantly reduced costs for law enforcement. However, as Wodak and Moore argue the challenge lies in convincing the community, or more specifically the electorate, that 'drugs are bad, but regulation is the least worst option' (2002:93).

Only then would we see the neoliberal project of partnerships involving users produce improvements in health outcomes for consumers and enable them to make significant contributions to reducing drug related harms. The pessimist in me sees this as a challenge that will take decades to implement, and until such time, as this research has shown, the existence of user advocacy groups will remain tenuous. However, if a truly rational approach to managing drug related harms does eventually prevail, then the neoliberal governmentality vision of 'governing at a distance' through the expertise of such groups may eventually be realised.

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